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What Works in Suicide Bereavement: What Helps and What Hurts?

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WHAT WORKS IN SUICIDE BEREAVEMENT:

WHAT HELPS AND WHAT HURTS?

by

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ABSTRACT

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By

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Suicide is one of the most painful grief experiences that any family may experience. The suicide bereavement literature, though small, is replete with research that shows family and systemic impacts of suicide. The literature also includes constant calls for family- and systemic-based intervention as every part of society is impacted. Research in the field of marriage and family therapy, however, has ignored suicide and suicide bereavement almost entirely. The purpose of this qualitative study is to develop a more thorough understand of the grief that survivors of suicide experience and to systemically understand what helps and hurts the grieving process. Three helpful themes and three harmful themes emerged with eighteen sub-themes between them. Suicidal ideation and preoccupation was another prominent theme that did not fit entirely in either theme as it was seen as a way of maintaining a connection to the deceased and so is included on its own.

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To my brother Eric, whose life and death had such a great impact on me that I found the motivation and desire to pursue graduate education that I have often believed far beyond my ability. I miss you greatly.

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CHAPTER 1: INTRODUCTION

Suicide survivors are, after all, people like us. Their circumstances are dramatic and painful, but all of us contend with despair, all of us have immutable pasts. Working with survivors illustrates the process by which we may be helpful to other patients. They make it impossible to ignore the past because the past intrudes on every moment. Their therapy demonstrates that mental health professionals who deal only with the present cheat the future as well as the past. Therapists cannot help their patients or themselves to approach that future without some understanding of all that has gone before. Shakespeare said, "What's past is prologue"; Wordsworth said, "The Child is father of the Man." Therapy must be the Lyceum in which psychotherapists are both students and teachers. They must adopt Hope as their mentor. They must use their skills and willingness to venture into the "dark night of the soul." Having done all these things and having given to the tasks all that they have been and seen and believed, then, and only then, do they and their patients have a chance to emerge into a "dawn [that] comes up like thunder" (Kipling, 1892/1937, p.48). (Chance, 1988).

Statement of the Problem

The last memory I have of my brother is a hike we took together when I was eight years old. We drove up to the mountain on which he later took his own life showed me his favorite hiking trail. Before we even actually began the hike I pretended to sprain my ankle. I wanted go home and watch Ninja Turtles. For months he was missing, our only clue being his Jeep that had been stripped of all valuables at the bottom of a ravine in the Four Peaks mountain area of Arizona. I don't remember when we knew he was missing, but I do remember laying on my bed at night crying because I missed my older brother—

my hero. When I learned that he had died on the very same mountain trail that he had attempted to introduce to me, I felt that his death had was my fault. Even at eight-years old I felt that if I would have continued that hike, I would never have lost my brother. As I grew up I often cried myself to sleep looking at the pictures that I had of him, wishing that I would have not been such a "wuss" and had been able to finish that hike. I thought that in that one hike, I would have been able to tell him I loved him and cared for him. If only he had known I cared, he would not have died. When I was a teenager, this guilt manifest itself as a deep feeling of depression and suicidality simply out of a desire to stop my own pain and again be with my brother. While my own religious understanding of death and the hereafter was complicated by his suicide, I knew that I died the same way we would be together. Today, I have found ways to live, love, and be near him. In a sense, my entire life has been dedicated to remembering my brother and create a as much positive meaning out of his and my family's suffering as possible. It is my motivation for this study.

Purpose of the Study

The purpose of this study is to frame suicide in an attachment and systemic lens with implications for family-based interventions both in and of therapy. Largely suicide and suicide bereavement have been neglected by the field of family therapy, despite the common practice of screening for suicide and suicidal ideation.

Significance of the Problem

In the past 45 years, suicide rates have increased by 65% worldwide, with nearly one million people dying by suicide yearly (World Health Organization, 2012a). Within the United States the rates of suicide per 100,000 hover between 10 and 15; with the rate

of men above 75 approaching 40 (WHO, 2012b). In Russia the rate is just under 40 for all ages (WHO, 2012c; the Republic of Korea the same—but over 65 the rates jump to 100 and nearly 150 per 100,000 for men (WHO, 2012d). The United States ranks 43rd for suicide rates; behind almost all of Europe and much of Asia—most notably is China which is the only country with a higher rate of suicide in women than men (Caruso, 2002). Suicide is the third leading cause of death among for ages 15-24—far above any disease or illness and just slightly below homicide and motor vehicle accidents (WHO, 2012a). According to Schneidman (1984), considered the father of suicide research, six people are affected by every suicide, with each being called a "survivor of suicide" though this estimate is sometimes considered conservative (Berman, 2011).

It is commonly thought, among laymen and professionals, that the survivors of suicide are the most challenging and difficult patients that mental health professionals will see (Chance, 1988). These survivors of suicide have a pervasive sense of helplessness which compounds their grief felt by a survivor of suicide is more difficult to cope with (Chance, 1988). There is often a failure to acknowledge the loss after a suicide (Feigelman & Feigleman, 2011) which can lead to disenfranchised or ambiguous loss (Boss, 1999). Suicide survivors themselves experience a higher risk of suicide (Clark & Goldney, 1995; de Groot, Neeleman, van der Meer, & Burger, 2010; Diamond et al., 2010; Hazell & Lewin, 1993; Parrish & Tunkle, 2003).

Death, Loss, and Bereavement

Prior to the 20th century death was not a mystery in the average household in the United States (Schowalter, 1987). Bereavement processes, however, have been standardized by laws and regulations and the societal shift to death occurring largely in a

hospital or nursing home rather than at home. Once, mourning largely occurred at home, now it has moved into hospitals and funeral parlors; laws that regulate the role of funeral directors and employees greatly influence how our society mourns and have creating an environment in which society sets limits on grief (Trolley, 1993). Many constraints on behavior and time have been imposed by workplaces and governmental institutions attempting to create a social uniformity to the bereavement process (James, 2008). While these movements have standardized expectations and beliefs about bereavement, they have also dehumanized one of the deepest and most human experiences—to grieve the loss of life. Though grief is universal, mourning and bereavement vary greatly between cultures (James, 2008; Weiss, 1998), periods of time (Dutro, 1994), and even with-in a singular culture. Mourning and bereavement may be the most culturally sensitive topics there are (Weiss, 1998).

Every human being will suffer loss. Some losses will be devastating, and some may be viewed as minor. The loss of a loved one is one of the most intensely painful experiences and one of the most difficult as the only thing that can bring true relief and comfort is the return of the deceased (Bowlby, 1973c). Death and loss are inevitable and painful parts of the human experience (Bauman, 2008). Recovery may take several years and may have a profound and lasting impact on the remainder of life (Finkbeiner, 1998). Although people cannot ever recover form death it is important to enable everyone—children and adults both—to reform a meaning of life, prevent enduring distress, and maintain spiritual, personal, and psychological integrity (Costa & Holliday, 1994).

There is often a failure to acknowledge the loss after a suicide (Feigelman & Feigleman, 2011) which blocks the coping and grieving process and results in an

ambiguous loss (Boss, 1999). According to Boss (1999) ambiguous losses are the most distressful of all due to the lack of clarity and lack of closure. This failure to validate the loss also creates feelings of powerlessness, shame, and self-blame (Boss, 2006). While grief and loss are universal experiences, complicated grief is estimated to occur 10-20% of the time (Shear, Frank, Houck, & Reynolds, 2005).

Grief and Bereavement in Suicide

Bereavement, of any type, is one of the most stressing and difficult events experienced in life (Mitchell, Wesney, Garand, Gale, Havill, & Brownson, 2007). It is often thought that suicide is the most problematic type of grief—but that is a lengthy debate and not the focus of this paper. While suicide bereavement is not shown as more difficult than other grief—it does exhibit differences and shares many characteristics with trauma-induced grief (Murphy, Johnson, Wu, Fan, & Lohan, 2003). Suicide bereavement is distinct from other bereavement in three specific ways: the thematic content of the grief, the social process of the survivor and surrounding systems, and how the family systems are affected as theorized by Jordan (2001). The loss of a loved one is one of the most intensely painful experiences and one of the most difficult as the only thing that can bring true relief and comfort is the return of the deceased (Bowlby, 1973c). When this loss is as a result of suicide the loss can be even more painful because the loss comes with the implication, "I would rather die than be with you."

Participants attending a suicide survivor group reported that messages understood through the suicide of a loved one include: "I can't handle the problem and you can't handle it either", "my death is preferable to my trying to work out my problems with you or through you; therefore, you and I are terribly distant", "I need no more people to love

outside of myself; therefore I reject you" (Battle, 1984, p. 53). Another implicit message was reported as the hated situation was seen as more important to the deceased than the loved ones or the affection for them. Further complicating the loss and adding to attachment injuries, survivors experience heightened feelings of isolation, rejection, and shame (Clark & Goldney, 1995; McMenamy, Jordan & Mitchell, 2008; Murphy et al., 2003; Sudak, Maxim, & Carpenter, 2008) and are viewed as less likeable and more blameworthy by peers (Calhound & Allen, 1991). In addition to the profound social marginalization, survivors struggle to share their grief with family (McMenamy, Jordan & Mitchell, 2008). This difficulty in sharing is a failure of the communication processes (Jordan, Kraus, & Ware, 1993) and leads to the issues of secrecy, blame (Parrish & Tunkle, 2003), conflict, and role strain (Diamond et al., 2010; Murphy et al., 2003; Sudak, Maxim, & Carpenter, 2008) that cause the family system—more precisely its inherent support system—to shut down. In these ways suicide has not only profound impact on the societal views surviving family members but also on the attachment views and behaviors within the family. Considering these familial and systemic implications suicide is not just an individual problem—it is a problem that concerns entire systems. It is an issue that must include family and systemic focus in both prevention and postvention, a term coined by Schediman (1984) referring to intervention for survivors of suicide that also acts as suicide prevention. The attachment implications will be explored and therapeutic treatment suggestions made.

Survivors of suicide face difficulties similar to those in other traumatic deaths (Cerel, Padget, Conwell, & Reed, 2009). Survivors have an increased rate of PTSD, complicated grief, and suicidal ideation (Cerel, Padget, Conwell, & Reed, 2009). Trauma

strains attachment bonds and severs important family connection—both internal and external (Miller, 1999). The bereaved will always maintain a connection to the deceased (Miller, 1999), but often will struggle to find ways to keep this connection. Trauma creates an environment that is a breeding ground for guilt. The feelings of guilt can be harmful to relationships by creating a feeling that positive relationships are not deserved, or create a fear of intimacy based on the fear that once these guilty secrets are shared they will be rejected (Matsakis, 2004). At the very time that survivors need people the most their traumatic reactions strain their relationship (Matsakis, 2004) and creating a double-bind that keeps survivors floating in a vast sea of helplessness and hopelessness.

The scope of this study is not to focus upon the prevalence of suicide or even solely its treatment but to focus upon healing process from the specific injuries that suicide leaves with the survivors, being that work with survivors of suicide is also prevention of further suicide. No bereavement process is easy or enjoyable; when this loss is perceived to be preventable, the grief is also perceived as more complex. This grief is more complex because a litany of should-have and what-if questions follow. While suicide bereavement does share many characteristics with other types of loss—especially that of traumatic loss—the complex processes and emotions felt by suicide survivors are unique as Jordan (2001) theorized in his review of literature). Specifically, suicide bereavement is distinct in the content of the grief, the social processes surrounding the survivor, and the challenges that family systems face as a result of the loss. The thematic content of suicide grief is significantly different in many ways. Perhaps the most prominent being that being the high levels of guilt (Allen, Calhound, Cann, & Tedeschi, 1993), shame, and blame experienced by survivors (Clark & Goldney,

1995; McMenamy, Jordan & Mitchell, 2008; Murphy et al., 2003; Parrish & Tunkle, 2003; Sudak, Maxim , & Carpenter, 2008). Forty-two percent of survivors were shown to exhibit high levels of shame and twenty-two percent exhibited suicidal thoughts of their own (McMenamy, Jordan & Mitchell, 2008, p. 383). Sudak, in describing his own grief after the suicide of his wife, said, "I felt (and feel) enormous guilt—despite knowing better intellectually" (Sudak, Maxim, & Carpenter, 2008, p.137). Guilt is a predominate problem (Lindqvist, Johansson, & Karlsson, 2008) in survivors. Many survivors also feel strongly that they could have done something to prevent the suicide and this compounds their grief with a sense of failure and shame.

Another prominent theme in suicide bereavement is the search for making meaning of the death (Jordan, 2001; Parrish & Tunkle, 2003). While this search for meaning is not uncommon in the any grieving process, this process can be time-consuming, long-lasting and may never be accomplished (Parrish & Tunkle, 2003). One parent survivor searched for an answer for eight years, but the only answer she received was that she may never find an answer; she did not like hearing there can be no answer, "I need to know," she said (Parrish & Tunkle, 2003, p.66). Another parent finally found an answer that provided him with some peace; he said, "He found a cure for his addiction when he shot himself. I think, at the time, he was so powerless over his addiction, and there was no other cure" (Parrish & Tunkle, 2003, p. 66).

Another theme of suicide bereavement distinct to suicide is that suicide ideation often follows (Clark & Goldney, 1995; de Groot, Neeleman, van der Meer, & Burger, 2010; Diamond et al., 2010; Hazell & Lewin, 1993; McMenamy, Jordan, & Mitchell,

2008; Parrish & Tunkle, 2003). One parent, describing the suicidal thoughts experienced after the son's death, said:

> I wanted to kill myself too, for a while. Not a long time, several months, because I had to find him and see that he was all right. He was my child, lost, and death was not a destruction of my being; it was just a process I had to go through. Release myself to find him. It was a logical thing to do (Parrish & Tunkle, 2003, p.68).

Twenty-two percent of those bereaved by suicide were found to have suicidal thoughts of their own (de Groot, Neeleman, van der Meer, & Burger, 2010; McMenamy, Jordan, & Mitchell, 2008). The last of the thematic content differences in suicide bereavement is its intense and prolonged duration (Sudak, Maxim, & Carpenter, 2008). Six months after the death participants report experiencing more guilt, sadness, and depression (Rudestam, 1977). While there is, initially, a great deal of suffering after the suicide of a loved one, there is a great deal of evidence that its bereavement process has profound effects even two or three years later (Jordan & McMenamy, 2004; Murphy et al., 2003). In fact, even five years after the suicide of a loved one, levels of distress and trauma were shown to be two to three times higher in survivors of suicide than the norm (Murphy et al., 2010). This is especially concerning when one takes into account that most bereavement services involve eight to twelve sessions spread over several weeks (Jordan & McMenamy, 2004).

CHAPTER 2: SYSTEMIC IMPACT OF SUICIDE

In line with McDaniel, Hepworth, and Doherty (1992), I assert that "there are not psychosocial problems without biological features and no biomedical problems without psychosocial features" (p. 26).To more completely address the systemic impact of suicide I will discuss suicide in in relation to biological, psychological, dyadic, family-of-origin, and socio-cultural influences, in-line with the Intersystems model proposed by Weeks (1989) with an additional section devoted to attachment concerns as I believe attachment significantly manifests in each of the sections.

Biological

While there is little in the literature discussing the biological impact of being a survivor of suicide, there are several profound implications. First, a study by Rudestam (1977) found that 23 of 39 survivors had no sexual desire since the suicide of their loved one. Second, Segal (2009) suggests that there is a biological and genetic predisposition to suicide through an exploration of suicidal ideation and attempts between identical and fraternal twins.

Psychological

Survivors are seen as more psychologically disturbed (Allen, Calhoun, Cann, & Tedeschi, 1993; Schneider, Grebner, Schnabel, & Georgi, 2011), seek therapy sooner and for a longer duration than others bereaved from natural causes (McBride & Simms, 2001). Major depressive episodes and PTSD are most common diagnoses with suicide survivors (Knieper, 1999). Mothers show higher rates of depression for longer periods of time than those that lost their child through and an accident or natural cause (Brent, Moritz, Bridge, Perper, & Canobbio, 1996). Child survivors are more susceptible to

mental disorders and suicidal behavior (Kuramoto, Brent, & Wilcox, 2009**)**. Survivors suffer GAF impairments, sleep disturbances, low self-esteem, and sad mood 18 months after loss (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004). Survivors of suicide also experience higher levels of anxiety than those bereaved by natural causes (Baten, 1999).

Dyadic/Couple Relationship

High quality relationships moderate the impact of trauma, trauma also intensifies the attachment needs for comfort and reassurance while also shattering the trust in the benevolence of others (Whiffen & Oliver, 2004) which leads to a negative impact on family and intimate relationship (Matsakis, 2004). Survivor couples experience increased marital dissatisfaction, friction, conflict, disengagement, withdrawal, a breakdown in communication (Whiffen & Oliver, 2004), and a decrease in sexual satisfaction (Whiffen & Oliver, 2004; Rudestam, 1977). Some survivors even refuse to marry and others refuse new relationships entirely (Schuyler, 1973).

Closely related survivors experience twice the level of complicated grief as distantly related survivors, with spouses, children, and parents experiencing the highest levels (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004). Interestingly, even ex-spouses and conflicted marriages were more adversely affected by the loss than higher quality relationships (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004).

While the death of a spouse is one of the most emotionally stressful and disruptive events in life, it seems to be less disruptive than the loss of a child (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004) as losing a child is often felt to be an impossible task (Finkbeiner, 1998). Survivor support groups are attended far longer in duration by

those that lost children or partners than bereaved siblings or parents (Feigelman & Feigelman, 2011). This task is even more daunting and demoralizing when the parents are haunted by the thought that they could have and should have seen the signs and prevented the death.

Family of Origin

After the death by suicide of a family member, there is an increased breakdown in the nuclear family and a decrease in dependence on the extended family (Trolley, 1993) After the suicide of 16-year old son the mother felt she has killed the boy, the older sister began talking about suicidal ideation, the father wanted to adopt a son to replace the loss—the wife wanted to leave the marriage and family for fear that one of the remaining two would hurt her (Schuyler, 1973).

Families will need to renegotiate roles and expectations; many families often begin to fill their void by filling it with another family member's role expansion (Jaques, 2000). It is critical to encourage open communication to resolve feelings about the stressful death by suicide within the family (Dane, 1991) Many intra-family conflicts center around the issue of mourning "properly" (Dunne, 1992). McMenamy, Jordan, and Mitchell (2008) found that sixty-four percent of suicide survivors had difficulty sharing their grief with family; sixty-one percent had trouble talking about the suicide at all. This difficulty in sharing is a failure of the communication processes (Jordan, Kraus, & Ware, 1993) and leads to the issues of secrecy, blame (Parrish & Tunkle, 2003), conflict, and role strain (Diamond et al., 2010; Jaques, 2000; Murphy et al., 2003; Sudak, Maxim, & Carpenter, 2008) that cause the family system—more precisely its inherent support system—to shut down. During the grieving process family have shown a decrease in

support for each other and become more distance because of the conflicts ; they often ignored each other as if they were invisible despite the desire to maintain family relationships (Tzeng, Su, Chiang, Kuan, & Lee, 2010) .

Paradoxically, support from family, though desired and often healing, is also related to higher grief symptoms and lower levels of life satisfaction (Ogrogniczuk, Piper, Joyce, McCallum, & Rosie, 2002). What is considered supportive is highly contextual, and may not be positive support even though well intended (Pais & Dankoski, 2011) Perhaps it is the reactions within the family that discourage communication (Tzeng, Sy, Chang, Kuan, & Lee, 2010) and efforts to alleviate one's own stress, guilt (Ogrogniczuk, Piper, Joyce, McCallum, & Rosie, 2002) or empathic distress, rather than to providing support. Overprotection is very common among families bereaved by suicide (Ogrogniczuk, Piper, Joyce, McCallum, & Rosie, 2002), perhaps out of the fear and belief and the experienced reality that loved ones can and do abandon us.

When seeking therapy family issues are the most frequently mentioned concerns (McMenamy, Jordan & Mitchell, 2008), and negative family functions are strong risk factors for future suicide ideation (Diamond et al., 2010). Even finding a way to grieve can cause family conflict, as spouses and siblings may view differing strategies of dealing with grief as inferior or even inappropriate (Parrish & Tunkle, 2003).

Socio-cultural

Many survivors find their social networks shrinking after the suicide (Feigelman & Feigelman, 2011) and it is suggested that commonly survivors socially isolate themselves (Schuyler, 1973). The Chinese saying, "Don't wash your dirty linen in public" and this culture—or any binding culture—can increase difficulty and a perceived

isolation or need to isolate (Tzeng, Su, Chiang, Kuan, & Lee, 2010). In a study comparing reactions to survivors of natural, accidental, and suicidal deaths, survivors and their families are seen as less likable and less supportable (Allen, Calhound, Cann, & Tedeschi, 1993). Through this expression of guilt and implicit shame the idea that survivors have done something wrong may begin to grow (Knieper, 1999). Shame and embarrassment imply dishonor or disgrace as if the survivor had failed their loved one (Knieper, 1999). Survivors report a high amount of negative support and even report being avoided (Wagner & Calhoun, 1991). Family and friends often accuse the bereaved for roles in the death (Feigelman & Feigelman, 2011). Men may find themselves coping in styles that attempt to mask fear and insecurity by remaining silent, being caught up in action, crying only when alone (Jaques, 2000) and often feel out of place even in suicide survivor support groups (McIntosh, 1993; Parrish & Tunkle, 2003).

A large proportion of people—in every society—even a majority, find faith to be the most important resource for coping, comfort, recovery, and growth (James, 2008). A truly effective therapist must be comfortable to assist clients to grieve and find healing in their faith and spirituality (Culliford, 2002). This is complicated because many faiths condemn those that commit suicide. Many survivors feel that at a time when their faith and community should support them even more they feel betrayed; there is a paradox of faith as a rock being turned into another stab in the back or another betrayal (Jaques, 2000). The support that is received is affected by society's view of suicide (Knieper, 1999). The belief system, philosophical ideas, and sense of priorities are challenged and questions regarding the meaning and even value of life emerge (Shneidman, 1977). Survivors are thrust into a deep confrontation with their beliefs, as well as the beliefs of

the society around them (Knieper, 1999), about death (Chance, 1988). Survivors may even question their own deeply held religious belief, if the manner of death may damn the soul of their loved one (Chance, 1988) or even a God exists. Survivors question their lives and their values (Chance, 1988). Religion and spirituality play a major role in the family belief system surrounding the suicide of a family member (Jaques, 2000). These religious and spiritual beliefs typically make the foundation of comfort and solace during times of difficulty—after suicide this foundation can be shaken (Jaques, 2000). Many organized religions view suicide as a sin. Often, a traditional burial or funeral is not allowed for those that die by suicide (Jaques, 2000) . Though having such a major role in bereavement, most bereavement research ignores the role of religious beliefs (Vandecreek & Mottram, 2009). In a review in 2009 only one published study and four dissertations that focus on religion during suicide bereavement (Vandecreek & Mottram, 2009). The Roman Catholic church maintained the view that those who die by suicide did not enter heaven (Aquinas, 1981; Augustine, 2003). While survivors do not generally believe this, it is still troubling (Vandecreek & Mottram, 2009). As said by a survivor in Vandecreek and Mottram's study, "And I do know that some people feel that's the ultimate sin…. I just know that God is fair. He knows our hearts and it'll be all right…I feel good about it." (2009, p. 747)

Several survivors were confronted by strangers that their deceased loved ones being in hell (Vandecreek & Mottram, 2009). "I will pray for her soul because she is probably not going to heaven." (Vandecreek & Mottram, 2009, p. 747) It is extremely important for clinicians to not omit the spiritual dimension of the experience of death, dying, and loss (Walsh & McGoldrick, 2004). The second distinction of the bereavement

felt by suicide survivors is the social process of the survivor and the surrounding systems. Perhaps the most prominent of social processes experienced by suicide survivors is that of stigmatization or marginalization. Despite the increasing awareness of suicide the stigma attached is still keenly felt (Parrish & Tunkle, 2003). One father that wanted to open up about his son's death, but was unable to speak to anyone about his son's death for four years, said, "The way they responded to me, everyone wanted to go about business as usual, as if nothing had really happened. Don't stir up any pain. Yeah, I think there could have been a different approach" (Parrish & Tunkle, 2003, p.69). As noted by Parrish and Tunkle (2003), society is not prepared to respond to the loss experienced by survivors of suicide, as is evident in the heightened feelings of isolation, rejection and shame felt by survivors (Calhound & Allen, 1991; Clark & Goldney, 1995; McMenamy, Jordan, & Mitchell, 2008; Murphy et al., 2003; Sudak, Maxim, & Carpenter, 2008). This isolation and rejection is evidenced by the finding that in cases of accidental death social interactions improved with positive changes seventy-six percent of the time, versus positive changes in only twenty-seven percent in the case of suicide (Range & Calhoun, 1990).

The support that survivors receive is affected by the society's view of suicide (Knieper, 1999). In a that study compared participants' reactions and impressions to a woman's bereavement, each tape was identical except the cause of death was listed as either a heart attack, suicide, or an accident participants rated the survivor of suicide as more psychologically disturbed, more ashamed, and more blameworthy (Allen, Calhound, Cann, & Tedeschi, 1993). Suicide survivors are also seen to be less likable and more blameworthy by their peers (Calhound & Allen, 1991), which then encourages

the stigma associated with suicide to spill-over to the bereaved survivors (Jordan, 2001). This stigma and its spill-over effect influence both individuals and entire family system functioning. Survivors of suicide are seen differently and more harshly than survivors of other causes of death (Allen, Calhound, Cann, & Tedeschi, 1993). Survivors feel shame, but feel as if they are treated as murders rather than the victims they are (Chance, 1988). Women in the suicide loss group report more sensitivity to rejection and more difficulty become close with others than the Natural Loss Group or Intact Family Group (Baten, 1999).

Attachment

There is an innate desire within all humans, and many animals, to be connected to others. Freud referred to this as the libidinal drive (Nichols, 2010), Fairbairn expanded this drive from purely sexual motivation to a motivation to maintain connection with significant objects (Nichols, 2010), Bowlby (1973a) refers to this drive as attachment. As described by Bowlby (1973a), attachment is an innate motivation, present at birth, to seek connection to others. This motivation also continues throughout life as we seek to maintain several intimate relationships. This attachment develops securely when caregivers respond to their children's cures and the child develops an expectation that when distressed someone will come to help. When there is unresponsiveness of an attachment figure the child experiences distress. When this happens consistently—or even inconsistently—over time, people alter their attachment strategies as a way to protect themselves in intimate relationships. These incidents of unresponsiveness create feelings of isolation, abandonment, and betrayal (Sayre, McCollum, & Spring, 2010) and

can considered attachment injuries (Johnson, Makinen, & Millikin, 2001) which seem to disproportionately influence the quality of the relationship (Simpson & Rholes, 1994).

According to Thomas Joiner (2005), suicidality results from a perceived lack of belongingness and a perceived burdensomeness. This feeling of belongingness is another aspect of attachment. When individuals are attached to others they feel connected, but also that there is a place where—or a person with whom—he or she belongs. Suicidal behavior—specifically threats and self-injury— are often interpreted as acts of communication directed toward a person of importance (Bonnar & McGee, 1977). A group of suicide attempters reported that their attempts were "a cry for help" and specifically directed towards their spouses (Bonnar & McGee, 1977).

Just as suicide itself, as well as gestures of suicidal intention, is a mode of communicating a deeply felt need for attachment, the implicit—or sometimes explicit—message sent to others is one of rejection and abandonment (Trolley, 1993). This message is also loaded with a statement of removing him or herself as a burden from those near (Praeger & Bernhardt, 1985), effectively choosing to disengage and distance (Prabhu & Bowers, 2010) rather than increase intimacy and closeness, which leaves the survivors feeling helpless and deserted (Schuyler, 1973).

McMenamy, Jordan, and Mitchell (2008) found that sixty-four percent of suicide survivors had difficulty sharing their grief with family; sixty-one percent had trouble talking about the suicide at all. This difficulty in sharing is a failure of the communication processes (Jordan, Kraus, & Ware, 1993) and leads to the issues of secrecy, blame (Parrish & Tunkle, 2003), conflict, and role strain (Diamond et al., 2010; Murphy et al., 2003; Sudak, Maxim, & Carpenter, 2008) that cause the family system—

more precisely its inherent support system—to shut down. When seeking therapy family issues are the most frequently mentioned concerns (McMenamy, Jordan & Mitchell, 2008), and negative family functions are strong risk factors for future suicide ideation (Diamond et al., 2010). Even finding a way to grieve can cause family conflict, as spouses and siblings may view differing strategies of dealing with grief as inferior or even inappropriate (Parrish & Tunkle, 2003).

No bereavement process is easy or enjoyable; when this loss is perceived to be preventable, the grief is also perceived as more complex. This grief is more complex because a litany of should-have and what-if questions follow. While suicide bereavement does share many characteristics with other types of loss—especially that of traumatic loss (Jordan, 2001)—the complex processes and emotions felt by suicide survivors are unique. Specifically, suicide bereavement is distinct in the content of the grief, the social processes surrounding the survivor, and the challenges that family systems face as a result of the loss.

Whether it is called lack of belongingness or thwarted connection, suicide is an attachment concern. More than just suicidality resulting from a pattern of attachment injuries, the act and gesture of suicide itself is an attachment injury that sends a message that "death is preferable" (Battle, 1984, p.53) to being with you. This is an example that demonstrates a way in which suicide and suicidality are not simply linear events. There is a circular causality in that one act or event is not a direct result of another—but each is multicausal (Weeks & Treat, 2008). There is an inverse relationship between suicide grief and intimacy and no relationship between level of intimacy and time since death (Maycock, 1997). Securely attached individual coped more constructively, through

lower levels of grief and higher levels in intimacy (Maycock, 1997). Despite the strong ties to attachment in suicide and suicidality, attachment is not discussed within the suicide literature.

Do Marriage and Family Therapists Avoid Suicide?

Some MFTs feel that accepting the existence of severe psychopathology is contrary to the systemic nature of the field (Denton & Brandon, 2011); only 29% of MFTs report feeling confident to treat severe mental illness (Northey, 2002). MFTs diagnose dysthymia, anxiety, and personality disorders less frequently than psychiatrists, psychologists, or social workers (Simmons & Doherty, 1995). There is a concern that MFTs are only qualified to treat a narrow range of "problems of living" and not mental disorders and an assumption that MFTs only work with couples and whole families, as mentioned by Simmons and Doherty (Simmons & Doherty, 1998).

Perhaps one factor that contributes to the lack of attention to suicide and its bereavement within MFT is the existence of a contraindication to therapy for grief. While there is often a call to begin suicide bereavement treatment early within the suicide bereavement literature (Dyregrov, 2009; Jordan & Neimeyer, 2003; Jordan & McMenamy, 2004; Laux, 2002; Murphy et al., 2003) there is also a suggestion that grief work should not begin within 6 months or even a statement that therapy may inflict harm (Bryant, 2007; McMenamy, Jordan, & Mitchell, 2008; Neimeyer, 2008; Rose & Bisson, 1998). Though there are studies suggesting that early intervention may be harmful it is not discussed within the literature on suicide.

What I Will Do and Why It Is Important

As Jordan (2001) mentioned in his review of interventions for suicide survivors there are few empirically sound studies that focus upon suicide survivors. Those that do exist use poor recruitment tactics, the most common of which is recruiting from prior support groups or professional mental health services. It is not sound methodological practice to apply findings on a broad basis when all studies are predominately white and female. It is well established that men are more violent than women, and more likely to follow through with suicidal actions; yet, suicide support studies focus upon support groups—an environment in which men do not feel as comfortable. There is substantial evidence that family based therapy is most efficacious, yet studies continue to utilize a structured support group setting. There is a general sentiment in the research that a true control group that denies therapy to survivors of suicide is not within ethical bounds. Yet, as reported by Hazel and Lewin (1993) there were not differences in outcomes between control and counseled groups. Even more poignant is the finding that some therapeutic processes are harmful to the coping process (McMenamy et al., 2008; Neimeyer, 2008). Considering that therapy may not help and may hurt a patient, establishing a control group is not unethical. Rather than accept an explanation of these disappointing findings as a result of the difficulty in keeping adequate records, or in the difficulty in finding a control group, I make the assertion that the therapy that is provided is inadequate or inappropriate. Often, it is both. With that being said, I must reiterate that there is no cure that works for all persons. Each person experiences grief differently—by degree, duration and maladjustment. Successful therapy must take the steps previously outline and adapt a therapeutic process that fits the needs of the

bereaved. Patients must be allowed to influence the type of therapy that they are provided.

While the systemic and familial necessity is profoundly supported within the literature, it is a topic that is largely nonexistent within the field of marriage and family therapy. It is my assertion that the attachment implications, the non-linear causality, and the familial impact make marriage and family therapists well suited to work both with persons struggling with suicidal thoughts as well as individuals and families grieving the loss of a loved one from suicide. This systemic focus also is well-suited with the integration of care across disciplines that is especially prevalent with suicide as survivors approach first responders, funeral directors, clergy, or doctors before a mental health professional (McMenamy, Jordan, & Mitchell, 2008). Another important focus of this study is that it is not specifically tailored to support group participants or therapy-attending clients. There is no data or estimation of the percentage of survivors of suicide that attend therapy or support groups but I believe it is accurate to say that most survivors do not attend formal mental health services. I believe that being a mental health professional is a job that extends beyond the walls of a therapy office and also has relevance to a more generalized population. Despite this fit, suicide is a focus that is almost entirely absent from the field of marriage and family therapy.

CHAPTER 3: METHODOLOGY

Rationale for Methodology

The aim of the study was to explore the process of healing in bereavement after suicide. The study examined the processes grief and healing from the perspective of the bereaved. Semi-structured, qualitative interviews with survivors of suicide were conducted to develop a deeper understanding of the process of suicide bereavement. The purpose of conducting a qualitative research is to understand the "inner experience of participants, to determine how meanings are formed through and in culture, and to discover rather than test variables" (Corbin & Strauss, 2008, p.12) Questions were asked in the interviews exploring processes that helped as well as processes that hurt. Specific, open-ended questions assisting to dig deeper into the processes of communication, comfort discussing the loss, increasing feelings of support and connection, increasing emotion and physical responsiveness, and stifled attachment needs.

As previously discussed, suicide and the bereavement from suicide have significant systemic and attachment implications. It is for these reasons that the field of Marriage and Family Therapy seems particularly well-suited to work with survivors of suicide, especially with the claim of MFT's unique qualification and success with family dynamics (American Association for Marriage and Family Therapy, 2011). Taking into consideration the implicit—and often explicit—ties our field has to attachment, it seems that this issue, of suicide and its bereavement, should be great fit for family therapists; especially in addressing the systemic implications that result from suicidal ideation, attempts, and completion. It is my hope that this study will help to enhance the current understanding of treatment and the healing processes through a systemic lens—one that is

rarely found in the study of suicide. It is further believed that this project provide research-based guidance for clinicians working with bereaved families, as well as the families themselves.

Participants

Anticipating participation to be difficult, a target of six to eight participants was set for the study; there were significantly more than six potential participants that expressed interest in participation but only six contacted the researcher. A total of 15 survivors of suicide made contact about participating in the research, however after two months only 6 had completed the interview. All participants were recruited from snowball sampling (Noy, 2008) through current Marriage and Family Therapy students at the University of Nevada, Las Vegas (UNLV). The research team printed and distributed flyers and more detailed letters that described the study. Social media platforms of Facebook and Twitter were also used to distribute the recruitment material.

To be eligible for the study participants were required to be at least of age 18 and self-identify as a survivor of suicide. There was no limitation based on gender, race, ethnicity, or time elapsed since death. Each participant was informed that the anticipated time from would be 30 to 60 minutes though there was no limit to allow each participant to fully process, respond to, and engage in the interview completely. Prior to the commencement of the Semi-Structured Interview Protocol (see Appendix B) each participant read through and verbally consented to be interviewed and audio recorded

Each participant was asked to complete a demographic form (see Appendix A) that asked the participant to self-report: age, gender, ethnicity, relation to the deceased, time since the death, and method of learning of the death. The participants ranged from

age 30 to 67, four being male and two female. Five of the participants self-identified as white and one specifically as Norwegian. One participant lost a child, one lost an ex-fiancé, three lost a brother, and one participant lost five family members. The most recent loss was 5 years ago, the other five ranged from 17 to 25 years ago. Two participants were informed by police coming to the home, three through phone calls, and one from a co-worker.

Procedures

Participants were given the choice of either coming to UNLV campus for the interview or agreeing upon another site that could protect their confidentiality; each participant selected their own home as the preferred place for the interview. Each participant was informed to anticipate the interviews lasting 45 minutes to an hour but no upper limit was set to allow for further exploration. The interviews were conducted according to the Semi-Structured Interview Protocol and follow-up questions were asked to further explore themes that may emerge within the interview and to heighten answers provided. This approach to research is outlined by Neuman (1994) as more cyclical than linear and highly effective for creating a more complete feeling for the whole, creating meaning in topics that are difficult to understand, and allowing space for opposing perspectives. Rather than a focus group format, each individual was interviewed individually hoping to allow a permissive environment to be created with a goal of encouraging discussing and expression of thoughts and feelings that might be difficult to admit.

Role of the Researcher

Being a survivor of suicide myself, I certainly have preconceptions of what other survivors have experienced. It is my own anecdotal knowledge, also supported in the literature, that contact with other survivors of suicide is healing. It was also my belief that sharing a little about my own story would help to join with the participants and help them to feel more comfortable to share their experiences with me as a researcher. This was certainly the case. Three participants explicitly stated they would not have participated had they not known I was a survivor of suicide. Through this method of bringing myself, preconceptions and all, to the research process I utilized myself as an interview tool. This means that though there were, at times, similarities to therapy—especially in normalizing a difficult emotion and enhancing minimized emotions—the goal of the interview was to understand the feelings, thoughts, and processes involved in suicide bereavement and not to fix it. At times each participant asked me questions as if I were an expert, like a therapist, seeking advice. As advised in supervision, permeable boundaries were set to separate advice from the research, but also to encourage the participants to have questions and bring them up in their own therapy or with family members.

Data Analysis Procedures

After each interview, the audio recordings were transcribed and analyzed according to a grounded theory process (Strauss & Corbin, 1990). Analysis was conducted by a team that consisted of myself and two other students Each member independently open coded the data and then met to discuss and agree upon prominent and common themes. Initially, the transcribed interviews were read for overall content, with no attempt to analyze. After this review was completed each helpful theme and each

hurtful theme was identified was a descriptive label. These labels were then compiled to notice commonalities and themes. Upon the initial analysis each participant was approached with the emergent themes and allowed to add or subtract any theme they felt was incomplete or inaccurate. This proved to be a valuable tool as most participants had reflected upon the interviews and were able to most coherently define their experience.

Researcher's Reflections

I was interested in this topic because it is something I have experienced myself and something that I and my family have struggled with. There is not much written about how to approach survivors of suicide and it is often done in a way that encourages us to create distance rather than closeness. I felt the need to add my voice and others to the somewhat limited body of literature that exists.

Through researching and writing I found that my own experience as a survivor of suicide was helpful in providing motivation to accomplish the required work. In interviewing each participant I found my own experience of grief and loss was invaluable in creating a sense of comfort and safety for the participants. There were times in each interview where each participant experienced a great deal of emotion and I was able to be with them and help to understand the feeling. Sometimes questions would arise not from academic research or education but because of my own anecdotal experience—I found this to be a useful tool in exploring some of the deeper and darker emotions felt. Every participant thanked me for including them in my study and said the interview had been a healing experience for them.

As I transcribed and analyzed the interviews I frequently was overwhelmed with emotion. At one point I curled up in a ball and cried for nearly an hour because I missed

my brother who died nearly 20 years ago. I was surprised because I have not cried like that since he died. It felt good to feel that raw and deep pain because it told me that I still love him. While continuing the analysis and writing process my feelings began to shift from pain and despair into anger—anger that my brother would be so wrapped up in his own issues of abandonment and rejection that he would pass them on to me. Though the emotions have been much more powerful and potent in the latter part of the study, I have often had to take time off from the work to be able to manage and understand my own emotions.

Another thing I noticed within myself while being so immersed in this interviews is that I felt increasingly insecure, within the relationship with my wife but also with friends, colleagues, and professors. Several months ago I had asked a group of colleagues to participate in a reflecting team to film a video about what qualities I would bring to a Ph.D. program for the University of Minnesota. While I was so immersed in these interviews and the feelings of responsibility that I, myself, felt after my brother's death I convinced myself that they would have nothing to say good about me. I also convinced myself that none of my professors would be willing to write letters of recommendation for me to pursue doctoral education. One of the participants frequently talked about his own perceived sense of worthlessness and I realize that is something I have been very familiar with throughout my life, even something that I experienced intensely while working so intently on these interviews.

CHAPTER 4: RESULTS

Each participant was explicitly and implicitly asked what has helped and what has hurt or hindered the grieving process. Three helpful themes and three hurtful themes emerged. Subthemes within these larger themes were also found, eleven that helped and seven that hurt. Two helpful subthemes were nearly impossible to distinguish from a larger theme, though it is believed by each reviewer that they are distinct—however there is insufficient distinction to be included separately. These two themes are included as parts of the subtheme in which they were found. Another theme did not fit into either category so is included on its own. These three helpful themes and according subthemes were :

1. Social support
    a. The funeral
        i. Respect
        ii. Feeling included
    b. Love and attachment
    c. Communication and talking about the suicide
    d. Connection with other survivors
2. Making meaning
    a. Letting it be good
    b. Making it have meaning
3. Continuing bonds
    a. Keeping memory alive through material objects
    b. Spiritual belief and continuation of existence

    c. Having experienced grief previously

The three hurtful themes and according subthemes were similar to helpful themes and often a variation or opposite of the theme that helped. These hurtful themes are:

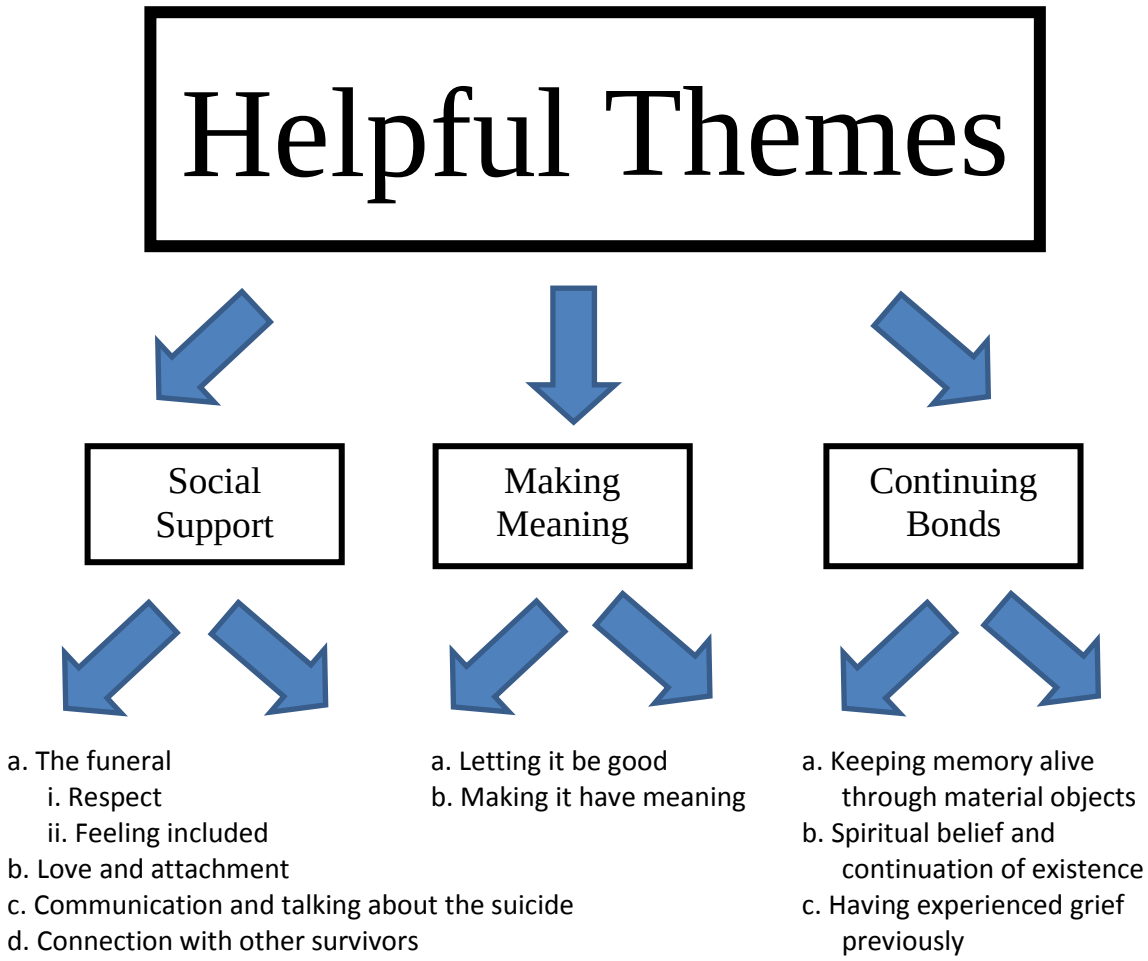
1. Isolation
    a. Feeling excluded
    b. Not being willing to talk about it
    c. Opposite of connection
2. Responsibility
    a. Feeling responsible for the death
    b. Pressure to be/replace
3. Lack of coping skills
    a. Addiction
    b. Suicidal ideation

Helpful Themes

While there are three distinct themes that are seen in the experience of being a suicide survivor, the subthemes within these larger themes often overlap. The subthemes that overlap between larger themes seem to be more helpful.

Figure 1

Helpful Themes and Subthemes



The Funeral

The funeral was specifically mentioned without prompt as an extremely important and healing part of the grieving process experiences with each of the six participants. Included in this funeral topic are sub-themes of feeling included in the process through helping to plan the funeral and a respect for the deceased. Participant 5 said, "Being included in the funeral planning was meaningful. It gave me some purpose." Participant 2 described her feeling of inclusion in the search for her son's body:

> [My son's captain] in the Air Force was very instrumental in helping me through the whole ordeal. I still have the notes of all his phone conversations and contacts. He promised to report back to me every 30 minutes or every hour. It was like clockwork. I could depend on a report from him on what was happening with the search. That was very helpful.

She further remarked that maintaining a schedule of what to do in preparation for the funeral and the paperwork for life insurance benefits and when to do it was helpful in getting through each day, it gave each day a purpose. Discussing the meaning of the funeral when her son had been missing for three weeks, Participant 2 said:

> There was a relief in knowing he was actually dead. To think that he had been so unhappy that he ran away or was going to live on the streets and turn away from his family and never speak to us again. There are so many things worse than death. Even though we had suspected he was dead, there was relief in finding his body. There was relief because we could have a funeral. We could pay respects. We could start to bring closure and start the healing, rather than the continued searching and unknown…My therapist wanted to come to the funeral out of respect to me, as a mother. That felt respectful to me. The idea of her clearing her calendar and doing that was meaningful. It was validating and respectful. She had been involved in all of it. The whole process. All the pain. It let me know she was not scared of it. My obstetrician cancelled all his patients and came to the services. That type of response [was helpful]. There was a man that Eric had [worked for] that came to the funeral. He was not a church-going man and had a long ponytail, but out of respect for Eric he came to the services inside of a

> church and cut off his pony tail because he wanted to show respect to Eric's belief. Those types of actions, to me, portrayed the respect and love people saw in Eric.

Another meaningful and respectful act that at the funeral was a meal that was provided by friends for the immediate family and military guests following the funeral service. Participant 2 describes this as meaningful not only as a labor of love but also because of a doctrinal talk that was distributed about suicide. She said:

> One of the ladies made copies of a talk by one of our highly respected church leaders called 'Suicide: Some things we know and some we do not' by M. Russell Ballard. She distributed copies of this article to all the friends that came to help with the family meal and gave a copy to me as well. I learned later from many people that this gave information about our church doctrine on suicide. It allowed us, it allowed me, to feel understand and respectful mourning of the loss of a wonderful person instead of pity, damnation, and gossip.

When asked about the repeated mentions of the funeral as a healing aspect, Participant 1 said, "I think it's a sign of respect to show up at somebody's funeral. I guess it lets you know you care. You say your goodbyes, things like that. It was pretty significant…I remember actually going to the airport and watching the baggage handlers crate the coffin out to the plane and put her on the plane and everything." Further describing the funeral and his experience:

> I remember at the funeral I stayed from the very beginning until the end when they closed [the casket]. Her daughter left and went to lunch…People would come in and out. It's almost like I felt like the guard on the tomb of the Unknown

> Soldier. I was on watch. I was there for anybody that would come in. I felt there should always be someone in the room and that turned out to be me. Even through the relationship ended and we broke up, we were still friends. I felt it was my responsibility to be there. I didn't want her to be alone.

Participant 6 recalled about the funeral that being so young, eight, at the time he knew very few people at the funeral and spent most of it wandering around the halls of the church, but during the service he spotted one person he knew:

> I saw my 2nd grade teacher sitting in the crowd. She never met my brother but she came for me. In the sea of people I didn't know I could see her face during the service. That meant a lot. That still means a lot.

Participant 4 recalled the benefit of the funeral, "I think the funeral was helpful, especially the prayer service where people would tell little stories...that was helpful."

Throughout the funeral and planning process respect for the humanness of the remaining family members and the memory of their dead loved one was extremely helpful—it was also helpful when completely separated from the funeral. Participant 5 described randomly meeting her brother's friends more than 15 years after his death:

> Connecting with his old friends means everything to me…His friend. When I see them something makes me really happy. When I'll bump into somebody and they'll say, 'This is Eric's sister. Remember I told you about Eric?' And they nod knowingly. It's meaningful to be with someone that knew him. It's nice to hear his name in conversation in a way that flows. His friends know how to talk about him. Which helps me to feel like he really did exist. That the relationship did

really happen and, in a way, still does. “This is Eric’s sister.” That’s a present tense statement. It just feels good.

Participant 2 said that anytime she meets someone that knew and loved her son she feels better, “Knowing that other people valued my son and loved him and respected his abilities and talents and the person that he was [is extremely healing.]” A theme that, at times, was tied to the funeral and had great impact on the perception during the funeral but also is specifically distinct was that of a spiritual belief in God and also continuation of existence after death.

Spiritual Belief and Continuation of Existence

A common theme among five of the six participants was their belief in a loving God as a comfort. Each of these five also expressed a belief that they will again see their deceased loved one. Even participant 1, that self-identified as mostly atheist, expressed, “It’s comforting to think that she in a better place…I’m hoping that maybe now she sees things clearly…that she can be happy now.” Further he said, “I’m not a believer in God…I didn’t do any praying or anything but I believe there is something out there.”

When asked about a possible spiritual struggle after the death, Participant 3 said, “God is my only comfort. My brother’s an angel man…I believe God has forgiven my brother for his actions and taken him in as his son. But for a long time, ‘Fuck God’ was my slogan. I felt that he had been punishing me.” Participants 2, 5, and 6, also report similar struggles with their faith and belief in God but that ultimately it has been a comfort. Participant 6 describes his own spiritual journey as searching for some church that would allow him to know his brother is not being tormented in hell for his sin of committing suicide but ultimately having a dream, “I wanted so badly to know if my

brother was in heaven or hell or what. But I had a dream and felt him. I don't know where he is but I know he's finally out of pain and he's happy. That's all I need to know."

Participant 5 expressed a similar experience while in labor with her first child, just three weeks after the funeral, that calmed her fears about her brother's fate:

> "Eric visited me when I was in labor with my first child. Eric was happy. Very, very happy. The person I have known before he became depressed. It felt like he was a messenger to me, conveying the joy he felt for me that my son would soon arrive. It was also a message of Eric's wellbeing, which was comforting and validating to me of the connection we shared."

While not a dream, Participant 2 describes a similar experience:

> It was the Mother's Day after his death. It was just a feeling like he was there with me. Made tears flow. You know a person. When you really know a person you know the feeling you have in their presence…It was loving. Comforting. Like he loves me.

Participant 4 describes a situation at the funeral that helped him, "The minister cited John 3:16 but changed it to, "For God so loved Tom that He gave his only Son. That was comforting…I pity anyone that has lost someone to suicide and doesn't have strong faith."

Through these spiritual experiences there appears to be a belief in the well-being of the soul of the deceased loved one, and even a belief that perhaps the torment and pain that was being experienced in this earthly life is now over. This belief is very similar to the next theme that was helpful of letting the death be good.

Let It Be Good

This theme of letting it be good is effectively a reframe of the death that really is more about the person that died than about the survivors. As described by Participant 2, "I have to make it as positive as [I] can because the hurt never goes away." Participant 5 experienced this as well, "After I had kicked around my anger towards him and blame towards him—which I feel was unfounded—after I came full circle [I learned] to let it be good." In explaining this idea Participant 6 said, "The first bit of comfort I ever felt about his death was when I learned of the depression he had been experiencing and the deep feelings of abandonment and unworthiness that was constant for him. It was comforting because I finally was able to think that his pain finally ended." Participant 1 said, "The first thing I thought was, 'She's out of pain. She's no longer hurting…She can be happy now." Participant 4 added, "It's comforting that at least he isn't suffering anymore."

In her decision to make it good, Participant 2 described how her son was deployed during Operation Gulf Storm and hospitalized due to the suicidal plans he had shared with his roommate. During his hospitalization she spoke with him, "He was separated from his family, friends, and the camaraderie of the Air Force…he called me on the phone. He was so happy to be [in the hospital]. He wanted help." The Persian Gulf War ended and her son was then sent home with direct orders to be met at the plane by the base psychiatrist and hospitalized. "[His captain] thought, 'Oh man, not Eric. We love Eric. He's been isolated and separated, he just needs time with his family. We'll bring him home, give him two weeks leave and he'll be fine. And so two weeks went by and

Eric was dead." With this mistake—going against medical advice—she was pressured by many around her to sue the Air Force, but decided against it:

> The decision I made was, 'It's not going to bring him back.' All it would do is drag his name through the dirt…The government would find some way to not remember him in a positive way. They will find some way to negate. I did not want to do that to his name. I wanted to keep his name in reverence. And money would not bring him back, it would not console me. But keeping his name in an honor would. So I chose not to sue.

Exploring this concept of choosing to keep her son's memory positive she further explained, "You have to make it a positive experience so that you can deal with it."

This reframe of death into an ending of pain and suffering was reported by each of the six participants and is very similar to the next theme. The next theme is also functionally a reframe, but one that is more about the living than it is about the dead. This theme is making the death have meaning.

Make It Have Meaning

The making of the death to have meaning is distinct from the previous theme in that it has little to do with the past and more to do with the future. Each participant mentioned some way in which they have made their loved one's death have a significant and positive impact on the future. Four of the participants reported going to school to become a teacher or counselor as their way of making the death have meaning; the other two use their own grief as a way to approach others that have similar experiences.

In explaining this idea Participant 6 said:

> For 10 years, I didn't talk about my brother's death. I kept it inside and it nearly killed me. I was thinking about suicide constantly, I mean I still do—but it was destructive then. Now, it's more positive. The first time I shared my experience of my brother's death a girl approached me and said she had been planning to kill herself but wouldn't because she didn't want her little sister to go through what I went through. That experience, that feeling that I helped—that my brother helped—another person became the focus of my life. It's the only way I have been able to be happy. By sharing my grief and pain and depression with other people I have over and over again found people that are desperate to know they are not alone. I can't bring my brother back—I wish I could—but I can make his death into a tool to prevent more death.

Participant 2 said:

> I went [back to college] and got my degree to become a teacher. So then, as a teacher because of Eric and because of my insight to the importance of relationships and the importance of having people that reach out to people that don't fit or march to the beat of a different drummer, it's made me more aware and more accepting and an advocate of those children in the classroom. It's made me look for those children that feel rejection or abandonment because those were issues with Eric…Becoming a specialist in gifted education helped me understand what needs my son had that were not being met. So it's an underlying motivation in my career development and its helped me become specialized in that which has benefited all my children. It's one way I make his death positive.

Participant 1 said, “I do not feel any responsibility over her death by not coming to pick her up now. That is from getting my bachelors in psychology. One of the first things I looked into was suicide.”

In using her experience to help others, Participant 5 stated, “I personally feel, on one hand, grateful because I have a knowledge about something that that I think can succor others that I would never be able to comprehend otherwise.” Participant 4 explained his understanding of this concept as beginning with the deceased being an organ donor, “Though the donor people were kinda rude to his wife, I said years later you’ll be glad at least some good came of it.” Delving further into this process of making good come of it he said:

> You talk to people and just about everybody’s been affected by suicide but nobody wants to talk [about it]. So I began to bring it up to somebody that has experienced that because I know what it’s like. So I’ll say, “I’m sorry to hear about your brother. I went through the same thing.” It’s like no matter how long it’s been—and most haven’t been that long—but it’s like they want to talk about it. It’s like one death prevented another. Hopefully some good will come.

Participant 3 added , “I’m not afraid to talk about anything that’s happened in my life—especially if it will help somebody else. It’s always lifted me up to talk about what’s going on.”

Having Experienced Grief Previously

Most of the participants had previously experienced the loss of a family member. It appears that this prior experience of grief may serve as a moderator to the distress experienced after suicide. Participant 4 explains, “Maybe because [I] had experienced

my parents' death not long before [it helped me] understand what to expect." As does Participant 2, "I had felt pain like this before, when my father died. I was very close to him." Participant 1 described his past, "Growing up the way I did death was a part of everyday life." Participant 5 states:

> If I hadn't already had the death of a close person that I loved, if I hadn't already grappled with that, then this one really would have put me in a tail-spin. But because I'd had that previous one and I had already dealt with it for 12 plus years, I was able to identify, "This is grieving. This is what a funeral feels like."

Love and Attachment

Within this larger theme of love and attachment are several subthemes that seemed, at times, intertwined. The helpfulness of this love and attachment is the security to be able to express feelings about the death, just being held—not left alone—when having difficulty. This is feeling unconditionally loved and accepted—being able to break down and it not being bad.

Participant 5 explained the support she received, "[my partner] was very supportive of any family gatherings. I never got flak for all the trips home. Any other time I would have. I didn't have to fight for anything surrounding the funeral." When asked if there was any memorable time about this support she said, "The day my mom called and said, 'We can't find Eric.' I just fell. Hard. I cried. He just hugged me. That was really good." She continued to explain the connection with her grief and her marriage:

> One time, 15 years later, we were driving around and he said, "Oh I was thinking about your brother the other day. You ever think about him?" I was like every

> single day. It was really nice that he talked about it…I loved being able to honestly say, "Yeah, I think about him every day. He was a very important person in my life"…Years later my partner suggested we name our youngest son after my brother…it was an honor. That was very healing, very supportive of him that it was his idea and he came up with it himself.

Describing the thing that helps him navigate his grief the most, Participant 3 described the relationship with his best friend:

> He's my friend, no matter what. He doesn't judge me. Loves me. No matter what…That's the only thing that has ever taken away the sting. He doesn't always answer his phone. He is a busy guy. But whenever he can. He's been rolling code on a fire truck and he'll answer his phone, "Hey brother, you ok?" He knows I go through it more than most people do. It kinda makes me sick that I'm the person [that is] emotionally unstable. Whenever he can he answers the phone to make sure I'm ok…"Is there anything I can do for you?" We do that. We always say that to each other. Always. It helps to know that when I reach he's there.

Participant 2 described her experience of support, "My spouse was very kind and loving. Non-judgmental…He gave my son's life history at the funeral and even included my son's birth father." She further describes how the dynamic of having the step-father preside at the funeral had potential to be incendiary with the birth father's presence but the step-father's inclusion of all members of the family—estranged and present—made it a safe and comforting place. "My current husband…acknowledged my first husband as the father and in a way that was kind, that was not blaming. That was supportive." She further describes that even now, more than 20 years after the death, her current husband

will show emotion or get choked up when talking about her son. "That helps. Of course that helps. My husband has been the most significant [comfort] because he's been by my side through it all. Been there with me." Participant 4 also identified his spouse as being a significant support.

Participant 6 recalled a time when he and his wife, then girlfriend, travelled to meet some friends and she asked questions about his brother:

> We ended up talking for two or three hours in my truck. Just the two of us. It was great because she wanted to hear how I felt. She wasn't scared of the baggage that I had been carrying for years. She wanted to see it all. Sometimes I would cry and she'd hold my hand. Sometimes she would cry and I would hold hers. It was then I knew I wanted to marry her because I wanted to feel this way all the time. Accepted. Good enough. I felt like she knew my pain and wanted to be in it with me. That one experience is probably the single most healing experience I've had.

Keeping Memory Alive Through Material Objects

Four of the six participants have very significant objects that help them to keep the memory of their deceased loved one close. Sometimes they have even begun to develop relationships and feelings towards these objects more than just the memory of their loved one.

Participant 3 mentioned having the guns that his brother and grandfather used to kill themselves in the closet. When asked if there is some connection there he responded, "Big. Big. Huge…I don't know how I the hell I do it, but when I pick up his gun I can shoot anything I aim at and hit it right in the middle. It's like he's going, 'To the left son,

pull the trigger.' It's like he's right behind me…As far as connection, it's something my brother had. It's the only thing that I have left of his." When asked what helps to keep the memory of his brother alive Participant 6 said:

> I have a windbreaker in my closet that he rode when he biked. I used to wear it but it's too small for me now. My wife has tried to convince me to get rid of it and I've tried. I just can't let go of it. Just like I have an old school Sony Walkman that he gave me that doesn't work anymore. That one is really difficult to let go because he gave it to me the last time I saw him. My wife sometimes calls me a hoarder because of it—even more because I also have an old Nalgene water bottle that my sister gave me. I lost the lid to it years ago but have carried it around with me and I get really defensive when [my wife] approaches me about getting rid of it.

Participant 4 reports keeping his brother's memory alive through the things left behind, "Sometimes we go through his stuff…he was a hoarder and we didn't know about it." Participant 2 has an entire room that holds memories and things that were her son's.

Communication and Talking About the Suicide

Each participant said communication about their deceased loved one and the suicide was helpful. Participant 3 said, "Talking about my brother's death is the one thing I got going for me." When asked what helps to communicate about the suicide Participant 2 said:

> Situations like this [help]. That somebody knew him and loved him and because they knew him and loved him experience the hole in the heart because he's gone…Being able to share that love. The more you love somebody the more it

> hurts when they are gone. It's also been helpful in a way that I've not experienced with anyone else to share the manipulative behavior that passed on my son's pathology and broken trust and hurt to all of us.

When asked if communicating about the loss was helpful, Participant 5 responded:

> Hands down. For sure. Beyond. Absolutely. Talking about it. Talking about memories. Talking about what happened. Talking about my relationship with him. Talking about anything about it is healing to me.

While discussing this communication and how to be able to talk about it, Participant 4 said:

> It's a little awkward bringing it up and you worry about opening a wound that hasn't healed. But it's not healed either way, so it's not like you're going to open a wound that has already healed. So far, I've never had anybody say to me, "That's so long ago I don't think about it anymore." I'm sure there are days that go by that I don't think of Tom but not very many. It's like the story of the little kid that watches a scary movie over and over again. When asked why he says he wants to do it until it doesn't scare him anymore. It's like that with Tom. Once you do that, then you can own that emotion.

Communication about the loss is one of the things that was helpful to all participants, but something that increased this helpfulness was when the participants were able to communicate and share stories with other survivors of suicide.

Connecting With Other Survivors

Often when the subject of suicide comes up the survivors feel marginalized or like nobody else could understand. Sometimes this connection with other survivors has a dual

role of creating meaning of the death, as was previously mentioned. Participant 2 explains her strategy to navigate some judgmental situations:

> Nobody understands if you haven't been there. And some people are very judgmental who really don't know and so it's been a strategy of mine to have a friend that shares a similar loss. [It helps] to have somebody that understands. All I need to do is make eye contact with [my friend] to negate something hurtful but unintentional and ignorant, and it negates the despairing remark.

Participant 3 explains his reservation in participating in the study:

> The only reason I'm talking to you right now is because you've been through it. I'm not going to talk to some dick who's never been through it before. Because it's none of his fucking business. If you've never felt the pain or the heartbreak or the utter feeling of somebody ripping your heart completely out of your chest and breaking every bone on the way [that comes] from somebody taking their life that's close to you, how in the fuck are you going to help me? How on God's green earth could you understand? How could you empathize or sympathize with anything that I'm feeling? With any one of the array of emotions that I feel in a 10 second timespan when you have no idea what it looks like? Like I said, I wouldn't have given you a second thought if you hadn't told me.

Participant 6 said about his own connection with another survivor:

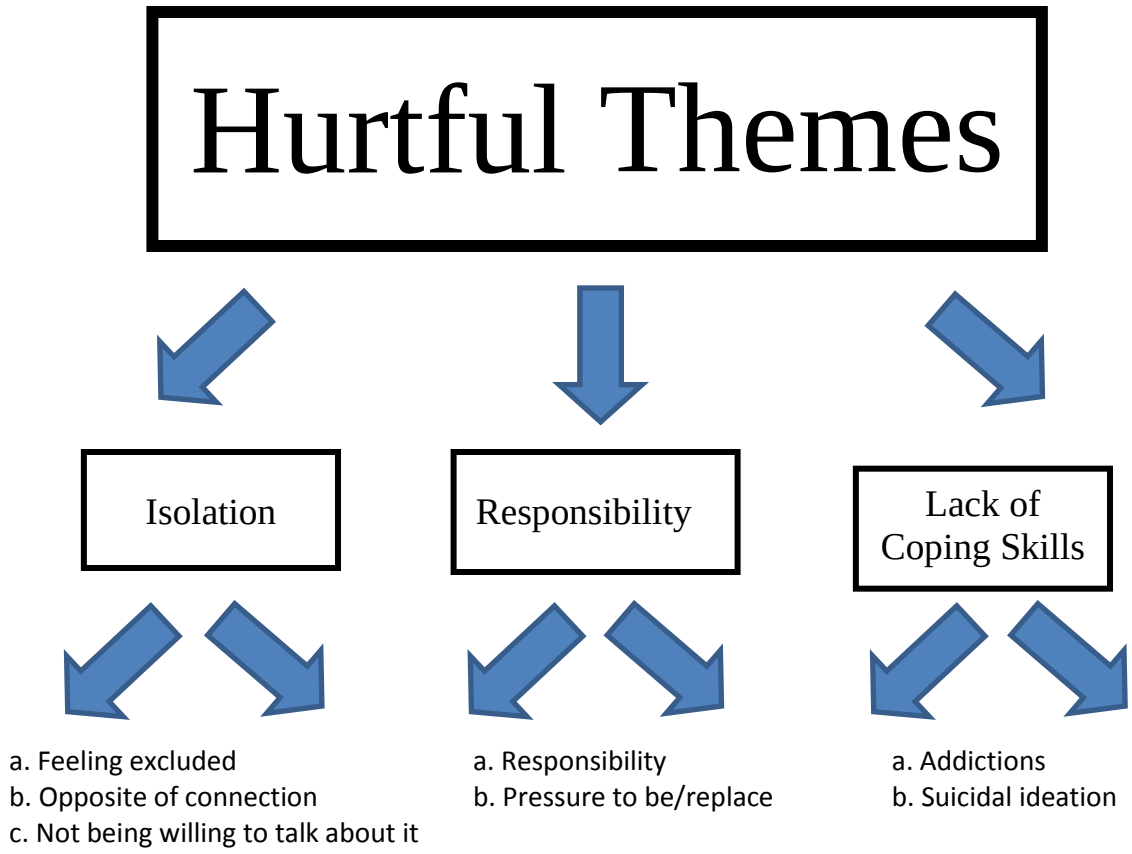
> One of the things that attracted me to my wife is that she shared with me she had an uncle that died recently. I shared with her that my brother had died by suicide. Then she shared that was how her uncle died. We both were so timid to share that pain—but it felt good to share it.

Hurtful Themes

Within the three larger themes of what hurts in being a survivor of suicide there are seven subthemes. Included within the theme of lack of coping skills is also the theme of suicidal ideation and preoccupation because it fits exactly into a lack of coping skills but it also has some helpful characteristics and so it is discussed separately as well.

Figure 2

Hurtful Themes and Subthemes



Responsibility

Each participant experienced some feeling of responsibility for the death. As Participant 4 stated, "It feels like you had a hand in their death. You know that's not true but that's not the way it feels." Much of this feeling of responsibility seemed to come

from an opportunity that the participants had to connect with their loved one shortly before the death. Participant 2 described he missed connection as travelling to Miami for business and not travelling up to North Carolina to visit her son while deployed. She further explained:

> While deployed, Eric called one day and asked me how I would feel if someday I learned he had been killed in a terrible car accident. He was experiencing severe emotional pain at this point, and my comment was I would be devastated. Horribly sad. But also relieved that he would be out of emotion pain for which there was no known resolution. Now, after thought this makes me feel this was his way of asking my approval to die, and I had unknowing of his suicidal thoughts, granted it. Another reoccurring and haunting thought I have is circumstances around Eric's birth. I was pregnant out of wedlock, and many people close to me suggested adoption. The birth father's first choice was abortion. No way was abortion an option I would consider, but I have often wondered if I would have placed my first born child for adoption, would his life been happier. Would he not be wounded with the feelings of rejection and abandonment that came with the divorce when he was six years old, and the 19 years of abandonment that followed.

Further describing this belief of responsibility Participant 4 said:

> You feel like there is something you could have done. The night Tom died I was within two miles of his house and I was running late between two calls and I didn't have time to stop…a few days earlier I'd asked if he had been busy, he said, 'Not as busy as you,' like I was too busy for him.

Participant 5 described her experience:

> The Sunday before [he died] my husband and I were visiting home and [he] was there and we were hanging out and having fun but [my husband] was bored and wanted to go home. So I made the judgment call to go be with my husband. But I wanted to stay but it was earlier in my marriage and relationships that id didn't really understand how much I could put down and say, "hey, this is important to me"…I was so focused on having a good marriage that I left. And that has been a great regret in my life. A very great regret, that I didn't stay thought I wanted to. Things were going well. He came over and visited me again, sort of saying goodbye to me. He withdrew emotionally, he wasn't there. I couldn't connect with him. I could feel it because I knew him. We had a great relationship but he wasn't making himself available…he wasn't real. I always wished that I could have broken through and helped him.

Further discussing this missed connection with the deceased she described how she and her coworkers had convinced their boss to let them leave work early because it was spring break and the office was deserted, "The day he set the suicide in motion, [He] called my work and I wasn't in the office to answer. I regret not staying my full shift to receive his phone call…It was devastating to me. He called my work and I didn't answer."

Participant 3 expressed his responsibility as a feeling that if he had been a better kid he would have been able to live with his brother, "I could have had [my brother's] attention or could have given him more confidence. There's a lot of scenarios that play through my head because I love him so much."

This last failed opportunity to be there described by Participant 1:

I got a call one morning…she asked me to pick her up at 5 am. I was still half asleep and said, 'who is this?' She said, 'This is D. Go back to bed I'll call you later.' And that's the last I ever heard from her". Processing this perceived responsibility he said that at the funeral it was his responsibility to be there for her, "I felt like I didn't want to leave her alone."

Feeling Excluded

When asked if there was anything that increased her pain felt after the death Participant 5 responded, "Feeling left out of the search. Being denied participation." She further described family counseling session the day after the funeral and felt that it was more hurtful than helpful, "At one point my mom fell apart. Which is not fair to her. It was too soon. The counselor had to stay in control [so she kicked us out]. Meanwhile we sat in the hall together and we needed somebody there with us." She describes it as feelings as if she were denied participation in the grief and as if she were being pigeonholed into a child-like role that had less importance or less understanding of the grief.

Participant 6 described his own feelings of being left out of the grieving process as a pattern that continued for nearly 20 years:

> It always felt like I wasn't allowed to be part of the grieving of my brother. I wasn't allowed to move or touch his things. I wasn't asked about him. I wanted to go look for him when he was missing but my parents continually made excuses to not allow me. My siblings and parents attended family counseling sessions but I stayed home 'because I was so young'. They didn't let me read his suicide note.

> I didn't even know he had written one until 20 years after his death. I remember when I was young I would sometimes wake up in the night crying because I missed him and I would take one of his pictures into my room. It always got taken out while I was in school and put back where it was before. It always felt like they were basically saying my pain wasn't real because I was a kid.

Opposite of Connection

While unconditional love and connection were both healing, the lack of them was not just neutral—it was harmful. Participant 5 describes her husband's attempts to deal with her grief:

> He was a fish out of water. He did the best he could to be there for me…I don't think it was good or bad. It was just fine. He let me do what I needed to do. It was almost like he was invisible because he didn't get in my way. It was a little awkward here and there…When I was sad or depressed he just wasn't cognizant or it, or didn't ask. He had moved on. I'd have liked more, "Hey how's it going with your brother?" If I had had a connected relationship with [my husband] I think that would have happened.

She further explains how she believes this lack of support was connected with their struggle to connect in general:

> Because we struggled with connection anyway he didn't know how to help me because I didn't stand up every day and say, "Hey, this is how I'm feeling and this is what I want you to do." It was frustrating that to feel like I was carrying something all by myself. I think that it is kinda an irritant to [my partner]. In the sense that I do truly, truly miss my brother. I did truly have a connection and a

love for him. I think there is a bit of, especially early on, jealousy. I think he felt competitive [for my love]." P5

Participant 2 describes how when someone "judges, glosses over, or ignores the loss" she feels like a significant part of who she is being rejected. Participant 3 describes how his struggles to connect in relationships impact his grieving process:

When I feel rejection in my relationship it brings back the instant sting of my brother's rejection. Or the abandonment. When we start breaking up and she starts leaving I feel that. Even if it's me that initiates the breakup, I feel abandonment. It creates feelings of rage. It creates feelings of all the insecurities, the fear and anxiety of all those things associated with post-traumatic stress from my brother…when I start to feel anything familiar with those feelings it triggers all kinds of stuff."

Not Being Willing To Talk About It

Participant 4 described how the political correctness that has become the norm in society may actually prevent people from being willing to talk about sensitive subjects:

It used to be that obituaries would say, 'John Doe died of a self-inflicted gunshot wound.' Nowadays we would never think of putting that in the obituary but I'm not so sure that was a bad idea…then you don't know when you see the family.

Participant 5 described an interaction with her little sister that barely remembers the brother that died:

My little sister doesn't want to talk about it and that's not helpful. It gets in the way of our connection. I wish she would let herself and talk more but she is uncomfortable with it. She doesn't enjoy reminiscing about him or even learning

about him. Not having that connection, or not allowing that connection to flourish about our brother is not healing for me.

Pressure to Be/Replace

Among the survivors, especially children, there is a commonality that they have felt a pressure to replace the sibling that died. Participant 6 described:

> I felt my whole life like I had to be this super man. This perfect kid that my mom deserves. Her first son killed himself. Her second son is schizophrenic. I can't be anything but perfect. I thought it would kill her. I always felt like I had to pretend my own struggles didn't exist because she didn't want to see them. That preoccupation with denying my depression and sadness damn near killed me.

Along with this theme of feeling a need to replace is the feeling that suicide is not an option. This feeling described by Participant 3, "I used to get so mad because he took my fucking seat. I always thought, 'man I can't do this to myself because he already did.' He took my chance." Participant 5 experienced similar feelings:

> I have felt pressure that I would be unstable…I have experienced clinical depression. I have felt in the past a pressure and a fear that that is just how we are. At the same time, I have felt pressure that I can't give up because I know what happens to people left behind. I have a pressure that I can't give up. I can't give up like he did. Even now, 22 years later, it's hard for my kids to have an uncle that committed suicide. Some of them are afraid they might do it too. It makes me angry that my kids have to carry the burden of having an uncle that committed suicide and from the public eye that is not seen as a virtue. It makes me angry that my kids have to carry the burden of this when it happened before they were born.

Addictions

While only explicitly mentioned and discussed in the interview with Participant 3 upon review of the interviews all participants except Participant 1 currently or previously have struggled with addictions. Participant 2 with work, 3 with alcohol and hard drugs, 4 with work and hoarding, 5 with eating, and 6 with sex. Upon member check each participant agreed to having struggled with the addiction and that the addictions began shortly after the suicide of their loved one.

Suicidality and Depression as Connection/Understanding

In addition to the themes in regards to helping or hurting, there was a notable theme that did not exactly fit into either category, in that it both helped to ease the pain of the loss but also was very taxing on each participant that experienced it. This was a theme of experiencing deep depression or suicidality.

While each participant reported experiencing extreme distress and depression even years after the suicide, three of the participants reported this depression as suicidal preoccupation and ideation (P5 and P6) or even attempts (P3). This suicidality and depression served to ease the pain of the loss in that the participants reported beginning to understand what it might have been like for their loved one before the death. Describing this one participant explained, "I have experienced clinical depression…it makes me feel better to think…that he was so depressed he couldn't think clearly. Or that he was in a really bad funk…that he experienced such long-term depression that without support he floundered" (P5). Another participant (P3) described it as:

> A person being in so much pain and so much grief and so much disorientation that they have to go…If they think that is the only thing they can do to stop the pain—

> I understand it. I've been there myself…[Having tried to kill myself] helps me to understand. It's like I'm loyal to him, my brother is the only one that ever had my back.

Further processing and attempting to understand the more of this connection between understanding suicide and being loyal Participant 3 explains, "He was my god. He was my everything…[When I tried to kill myself] I just wanted to get to him…I wanted to be next to him" (P3). Another (P6) described it as:

> In a lot of ways these suicidal feelings are how I feel my brother close to me. I don't know if he's in heaven or hell or neither, I just know I want to be with him.
>
> I knew that if I killed myself I would be where he is. I just want to see him again.

This experienced depression and suicidal are paradoxically experienced both with disdain and fear but also fondly because of the connection to the deceased loved one that comes with it. Participant 3 explains, "I worry about tarnishing my brother's memory. He's the only person on this whole entire world I've ever been loyal to…I don't want erase or replace him. That would ruin everything."

CHAPTER 5: DISCUSSION AND IMPLICATIONS

The intent of this study was to more fully understand the experience of being a survivor of suicide, as well to what helps in the grieving process and what hurts. The three helpful themes that emerged from the data were social support, making meaning, and continuing bonds. Subthemes that were found to be helpful: 1, the funeral along with respect and feeling included; 2, spiritual belief and continuation of existence; 3, letting it be good; 4, making it have meaning; 5, love and attachment; 6, keeping memory alive through material objects; 7, communication and talking about the suicide; 8, connecting with other survivors. The three emergent hurtful themes were isolation, responsibility, and lack of coping skills. The subthemes found to be hurtful:1, responsibility; 2, feeling excluded; 3, opposite of connection; 4, not being willing to talk about it; 5, pressure to be/replace; 6, addictions; 7, suicidal ideation. Another theme found was that suicidality and depression functioned as a method of connecting with and understanding the deceased—that was both helpful and harmful at the same time.

Helpful Themes

The funeral. While each participant explicitly mentioned the funeral as a healing part it was also implicitly discussed through themes of respect and feeling included in the healing process. Planning the funeral and searching for the victim of suicide were all mentioned as ways of being included in this process. Attendance at the funeral and honoring the humanness and life that each victim of suicide had appeared to be large parts of this theme.

Attendance at the funeral was a way to show respect for the life that the victim of suicide had; it was also respect for the love the survivors have and their pain. It let the

survivors know that people cared and valued their loved one. The funeral also appears to function as a sort of tangible aspect of the grieving process that allows survivors to have a purpose and a meaning. Feigelman and Feigelman (2011) discuss the importance of acknowledging the loss after suicide. Boss (1999; 2006) notes the funeral as a powerful ritual that can help families to fight shame and lack of clarity of loss. It also functions as a catalyst to allow survivors to share stories and talk of their grief. The funeral was also closely tied to spiritual belief and even of the belief in being reunited someday.

Spiritual belief and continuation of existence. Five of the six participants explicitly stated they believed that they would one day be reunited with their deceased loved one as part of their spiritual belief. Half of the participants reported visitations or dreams of the deceased in which a message was relayed. A message that the deceased was not in eternal torment but that the deceased still loved his family and that he was still a part of their lives. These visions or dreams communicated to the survivors that their loved one was finally out of pain and happy. Part of this spiritual theme is a belief in being forgiven and healed by a loving God. This belief in forgiveness ties closely into the belief of letting the death be good.

Letting it be good. Much like the belief of forgiveness and healing provided by a loving God, this theme primarily is seen as a belief that the intense emotion and physical pain that has been endured for years by the victim of suicide has finally ended. This theme is very similar to a reframe in that the death of victim of suicide is changed from a negative experience of loss and into a positive experience that the pain is finally over. This reframe focuses not upon the survivors of suicide but upon the victim of suicide and the pain and torment that was being experienced. Participant 2 explained it most

powerfully when she said, “I have to make it as positive as [I] can because the hurt never goes away. [I] have to make it positive so I can deal with it.”

A significant experience within this theme was the decision Participant 2 made to not sue the Air Force for her son’s death—as they went against medical advice. Her decision was to keep her son’s name and reputation in good standing with the Air Force because that honor would help her to remember him fondly and money would not end her pain—remembering her son in the best light possible would help however.

Making it have meaning. This theme is very similar to the prior in its reframe-like quality except the focus is not upon the past but upon the present and future. Rather than victim’s experience being reframed, the survivor’s experience is reframed to make the death have positive meaning for the future. Each participant mentioned their loved one’s death as a significant and motivational factor in their current life. Four of the participants reported returning to school to become teachers or counselors; the other two use their grief to help others that are bereaved. Participant 6 shared a story that through sharing his experience he was able to connect with a classmate that was suicidal herself. Through this connection he was able to help another and he feels as if his brother was able to help this girl and her family from future pain. All participants have used their experience and grief as a way to connect with others similarly bereaved.

Connecting with other survivors. The theme of connecting with other survivors functions as a dual role in creating meaning, as previously explained. One of the reasons that the participants founds connection to be so healing is the normalization experienced when able to speak with someone that understands the pain, the experienced shame, and the feelings of responsibility. Participant 2 stated, “Some people are very judgmental

who really don't know and so it's been a strategy of mine to have a friend that shares a similar loss. [It helps] to have somebody that understands. Three participants only agreed to participate in the study after they learned that I was a survivor of suicide myself. Participant 6 explained that both he and his wife had lost family to suicide and it was one of the things that bonded them together because they were both able to express their feelings entirely and feel understood and accepted. Much along the lines of feeling entirely accepted and understood through connection with other survivors is the next theme of love and attachment.

Love and attachment. The feeling of love and attachment is a theme that is at time intertwined with several other subthemes that can be difficult to distinguish. This feeling is having the connection with attachment figures to express positive and negative feelings without fear of being loved less. This is shown as feeling unconditionally loved and accepted—of being able to break down it be ok. Feeling alone and rejected was common for each participant and having a friend or romantic partner willing to experience the pain and sorrow with the survivor was extremely healing. Participant 6 reported a time when his wife—who was a girlfriend at the time—asked to hear about his brother. Never before had anyone asked. He was able to share who he really was. She wanted to see it all. He said, "She wanted to see it all." He felt accepted and good enough for her love. He reported this experience as the single more healing experience since the death.

Having previously experienced grief. Four of the participants had previously experienced the death of a family member and each of these four seemed better able to cope with the death. It appeared in the interviews that understanding of what grief is might act as a moderator to the distress after suicide. While the experience of death once

was common in the average household (Schowalter, 1987) this is no longer the case as death has moved from the home to hospitals and nursing homes—away from everyday life. This can even be seen in distracting children from experiencing the pain of loss of a pet or toy by the purchase of another to avoid the feelings of loss.

Keeping memory alive through material objects. Four of the six participants had objects that they considered very significant to keeping the memory of their deceased loved one close. At times it appeared that the survivors may have begun to develop relationships with the objects and feelings towards them as more than just a memory of their loved one. While this was experienced as a helpful part of the survivors' experience it seems very similar to a maladaptive bereavement practice of described by Field (2006) in his discussion of continuing bonds and also very similar to the relationship developed with material items in hoarding. Continuing bonds will be discussed in more detail later.

Communication and talking about suicide. Each participant reported communication about their feelings and the suicide to be helpful. While each participant has experienced the stigma of suicide one of the participants feels as if the political correctness adds to this stigma and difficulty in talking about suicide. He believes that newspapers including the cause of death as suicide would be helpful in talking about the feelings involved. This same concept was mentioned as helpful by another group of Norwegians—this participant reported his ethnicity as Norwegian—in a similar study (Grad, Clark, Dyregrov, & Andriessen, 2004).

Hurtful Themes

Responsibility. Each survivor experienced feelings of having responsibility for the death. Participant 4 stated the concept well when he said, "It feels like you had a hand

in their death. You know that's not true but that's not the way it feel." It appears that much of this feeling of responsibility comes from a missed opportunity to connect with the victim of suicide shortly before the death. The participants feel that if they had shown more care or concern for their loved one perhaps the outcome would have been different. Participant 2 has wondered since the death, more than 20 years ago, that when she got pregnant out of wedlock perhaps she should have placed her son for adoption rather than raise him in an unhappy marriage from which he developed his deep feelings of rejection.

Feeling excluded. Two of the participants recalled specific instances in which their pain was intensified through feeling excluded from the grieving process. Participant 6 reported not being included in the family counseling sessions was hurtful even though he was young. He felt as if his pain was ignored because he was so much younger than his family and he didn't learn the truth about the circumstances of the death until 20 years later. While this feeling of exclusion can be very similar to the lack of connection that will soon be discussed it is more than just an exclusion from family.

Opposite of connection. While unconditional love and acceptance were some of the most healing things experienced by survivors the lack of love and acceptance was one of the most hurtful. Participant 3 described how each time he feels rejected in a relationship it brings back the sting of the rejection he felt when his brother died. Instantly his fears of abandonment return and he begins to self-destruct. These feelings, both of exclusion and of lack of connection, are further supported through reports of survivors experiencing increased isolation, rejection, and shame (Clark & Goldney, 1995;

McMenamy, Jordan & Mitchell, 2008; Murphy et al., 2003; Sudak, Maxim, & Carpenter, 2008) and even being liked less by their peers (Calhound & Allen, 1991).

Not being willing to talk about it. It was framed by Participant 4 that the political correctness of fear of offending or discussing difficult topics is harmful to the process of healing because people desire so much to talk about it. Participant 5 shared stories of how her sister's lack of comfort in discussing the loss harm the connection and process of healing.

Pressure to be/replace. All participants that lost a sibling (four of the six) reported a feeling that there was pressure to replace the sibling that died. There was also a pressure that they themselves would be emotionally unstable and flawed. Interestingly, this feeling of being flawed and fear of being suicidal is paradoxically also experienced as a feeling that suicide is not an option. Three of the survivors experienced their own suicidal feelings—one attempted—and felt that by not being "allowed" to be suicidal they became more suicidal. This pressure is connected to the theme of suicidal ideation that will be mentioned later.

Addictions. Though only explicitly mentioned by one participant upon review of the interviews a theme of addiction as a way of coping with pain was apparent.

Apart from the themes already discussed it is important to discuss the last theme that emerged from the data. This theme was the experiencing of suicidality and depression as a connection and understanding of the deceased. This theme was helpful to the grieving process because it allowed each participant that experienced to have more compassion and understanding for what the victim of suicide had experienced before the death. Further than this understanding this suicidality was also experienced as a way of

reconnecting with the departed loved one. These preoccupations were ways in which the survivors could maintain a connection with an attachment figure. Participant 6 said, "I don't know if he's in heaven or hell or neither, I just know I want to be with him again. I knew that if I killed myself I would be where he is."

Among the themes that emerged from the data there does seem to be a connection with the deceased and other survivors that seems to be helpful. This theme of maintaining connection to the deceased seems to be very similar to—if not the same as—the concept of continuing bonds (Klass, Silverman, & Nickman, 1996). While this connection to the deceased does seem to provide great comfort to the participants of the study it also has its maladaptive consequences.

The maladaptive consequences of these continuing bonds are most prominently seen in the pressure to be and to replace. This was experienced by Participant 6 feeling an expectation to replace his deceased older brother and also in Participant 5 in her lack of connection with her partner. Participant 5 explicitly stated that her partner felt a competition for her love and affection with her deceased brother. Participants 4 and 6 reported a connection to their dead brother's through objects—Participant 6 and 4 report their own struggles with hoarding as part of their bond.

The results from this study are in line with much of existing literature on suicide bereavement—it is a problem that is impossible to separate from the systems in which it occurs. Each participant discussed familial, social, and dyadic issues as some of the most harming and some of the most healing. Along with these systemic implications it appears that the attachment beliefs are suicide survivors may be significantly altered as a result of the deep feelings of rejection and abandonment of being left behind. Though

beyond the scope of this study, there seems to be evidence from four of the six participants that the internal working models (Bretherton, 1985) of suicide survivors are altered through the experience.

Due to the systemic and attachment-related nature of M/CFT it seems that these systemically-trained therapists are a needed resource in the field of suicide and suicide bereavement. The emergent themes of healing and harming are experienced across many healthcare, societal, and intergenerational family systems and an integration of healthcare seems to be a very appropriate approach.

Clinical Implications in Family Therapy

The intent of this study was to further understand what helps and what hurts the grieving process after suicide. While specific interventions, theories, and modalities are largely absent within the results there are a few recommendations that can be made with the data.

The Double Bind. The most prominent clinical implication that sticks is the theme of suicidality and depression as a connection to the deceased. Much like in working with addictions, there may be resistance to "feeling better" as the feeling of suicidality maintains a connection with someone that is no longer present. Externalizing and framing these feelings in a negative light may be met with resistance as they also provide comfort in a time when there is so little comfort.

When this suicidality is also experienced with the pressure to be and to replace the deceased the feelings are compounded. Survivors may feel resistant to "feeling better" for fear of forgetting or dishonoring the deceased but at the same time feel that suicide is an unacceptable option; this potentially places survivors in a double-bind (Bateson et al.,

1956) in which psychotic behavior may make sense. As described by Boss (2006) the way to approach binding paradoxes like this would not be to completely eliminate one or the other, but to embrace them both and learn to live with them rather than without.

This bind that functions within survivors' own internal struggles also plays out on a familial and societal level. The trauma strains attachment bonds and even creates feelings that positive feelings or relationships are not deserved (Matsakis, 2004) but it is these positive feelings and relationships that the survivor craves most (Ogrogniczuk, Piper, Joyce, McCallum, & Rosie, 2002). Some survivors refuse to create new relationships for fear of being further abandoned (Schuyler, 1973).

The Myth of Closure. Each participant at one point in the interview referenced the five stages of grieving popularized by Kübler-Ross (1969) and compared their own grieving to these five stages. The culminating stage of Kübler-Ross's theory is acceptance which comes along with the implicit message that once accepted the loss will no longer severely impact those left behind which is at times described as the end of mourning (Hagman, 1995) or grief resolution (Field, Gao, & Paderna, 2005).

Rather than defining grief as a process that has a clear end Bonanno (2009) describes grief more as oscillation during which some periods are sad and some are not. Others have embraced an idea of living with the grief rather than getting over it (Becvar, 2001; Boss & Carnes, 2012; Neimeyer, Harris, Winokuer, & Thornton, 2011). Perhaps it is the type of loss (Currier, Holland, & Neimeyer, 2006), the relationship to the deceased Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004), or an interplay of both (Holland & Neimeyer, 2011) but it appears that the "traditional" timeframe (Murphy et al., 2010) or model of grief resolution and acceptance does not apply to survivors of suicide.

Five of the six participants experienced the suicide of their loved one more than twenty years ago but not a single one has considered themselves at the end of the mourning process. While the interviews were not therapeutic nor assessing, it seemed that the participants were largely very highly functioning but the loss of their loved ones was very obviously still an important issue. As was mentioned by Participant 4, in his efforts to talk with any survivor he comes across he has never met anyone that says the loss was so long ago they hardly think of it anymore. Anecdotally, this has also been true in my experience.

While there are certainly a great deal more therapeutic implications the two mentioned were the two that appeared most prominent to me. As previously mentioned, an integrated healthcare approach also seems to be a very appropriate model to helping survivors of suicide as their experiences span biological, psychological, romantic, familial, social, and spiritual realms. It is also apparent that most of the emergent helpful themes have many systemic implications; every hurtful theme has deep systemic implications. Due to the fact that so much of Marriage and Family Therapy emphases systemic and collaborative care it would seem that concerns within suicide and suicide bereavement are completely within the scope of Marriage and Family Therapy. However, there appears to be a gap within the admonitions for integrating health care and the practice of integrating research across disciplines.

Future Directions and Limitations

One of the strengths of this study is the fact that none of the participants were recruited from a suicide survivor support group—as most studies on survivors involve attendees of support groups. Another strength would be that four of the six participants

were male as most participants in the existing literature are female. At the same time a strength and a limitation would be that the most recently bereaved participant was more than five years prior to the interview, with most being more than twenty years bereaved.

As has been found previously while studying violent loss (Currier, Holland, & Neimeyer, 2006) sense-making appears to be an important part of the grieving process. The concepts of resilience and even more of post-traumatic growth (Fiegelman, Jordan, & Gorman, 2009) seem to be present in these survivors of suicide—particularly of resilience in Participant 4 and post-traumatic growth in 1, 2, 5, and 6. Participant 4 had experienced the suicide of his brother most recently—just over five years ago—but reported significantly less distress now and immediately after the death than the other participants. Further inquiry to understand the potential resilient factors would be of interest. These concepts were largely outside of the scope of this study but warrant further study as few articles specifically addressing resilience or post-traumatic growth in suicide survivors were found upon preliminary search.

Each of the six interviewees identified a spiritual or religious belief provided some of the most comfort—mental health professionals would be well-advised to use each client's own spiritual or religious milieu as a therapeutic tool. Even participants that reported being largely atheist find this belief to be comforting.

Though only a sample size of six it is worth noting that four of the six experienced the suicide more than 20 years ago and these themes are still vivid and most are experienced daily. A similar study involving survivors that are more recently bereaved may be beneficial to more fully understand the process. Initially I had wanted to include the Integration of Stressful Life Experiences Scale (Holland, Currier, Coleman,

& Neimeyer, 2010) as part of the study but it appeared to be beyond the scope of the project. However, after analysis of the interviews I do believe that a future study utilizing the ISLES would worthwhile, especially with the more recently bereaved.

Spirituality was viewed as such an integral part of the healing process of five of the participants it begs the questions what is the experience of Atheist and Agnostic survivors. This issue of spirituality, while a large theme in the participants, is also one of the limitations of the study in that it does not apply to persons without this spiritual belief. It seems that the issue of spirituality and a belief in a loving God may be similar to the concept of God as a secure attachment figure (Kaufman, 1981) and may further examination.

It is worth noting that the three participants having avoidant or anxious/ambivalent all lost attachment figures during adolescence or childhood. Future studies may explore this in further depth. It also appears that a secure attachment to an intimate romantic partner serves as a great mediator to the grief experienced after suicide. Along these lines it also appears that a more in-depth look at love and attachment in suicide and suicide bereavement could be its own topic.

It seems that there is a distinction in the grieving process based upon age at which the death happened. Five of the six participants experienced a great deal of shame but a further understanding of this concept was beyond the scope of the study. Further ideas for future study would be a more in-depth look at each of the themes that emerged from the data. Particularly I am interested in the process of letting it be good and Participant 2's decision to not sue. Throughout the interview it seems this decision is the most

healing part of her grieving process. Understanding how a grieving mother makes this decision may help others in her situation be able to make a similar decision.

Other limitations of note would be that five of the six participants had experienced their loss more than 20 years prior. The content in this study may not accurately reflect the recently bereaved. All six of the participants identified as Caucasian and from the rural western part of the United States.

APPENDIX A: DEMOGRAPHIC FORM

What is your age?

What is your ethnicity?

What is your gender?

What is your relation to person who died by suicide?

When (how long ago) did the death occur?

How did you learn of the death?

APPENDIX B: SEMI-STRUCTURED INTERVIEW PROTOCOL

Begin by sharing my own story of being a survivor of suicide and how this has led me to conduct research on the topic.

What is it like to be a survivor of suicide? What do you feel/think/fear/hope?
What hurts the most? What makes things hurt more?

Which events do you think were most harmful to your healing? Why?

Were there any significant moments where somebody did something that helped in your healing?

Will you describe some of the significant relational moments, wherein your partner said or did something that helped you in your healing? How did your feelings change as a result of that?

What events do you consider to be the most impactful with regards to your healing?

Many survivors of suicide report searching for a meaning or making sense of the death, will you describe some of the meanings you have found, if any?

How has the relationship between yourself and your family or friends changed since your loss?
How have you strengthened ties to your family or friends?
How have you strengthened ties to the deceased?

Some survivors of suicide find communication about the loss to be healing. Is this the case for you?
What have you done, what has happened, to help increase your communication?
How has talking about it helped?

What has helped you to increase your comfort discussing your loss?

How did the way you feel, think, and act after the death change?

How do you feel, think, and act now?

What has helped you to increase your knowledge, acceptance, and communication about your feelings since the death?

Many survivors report fear losing other people close to them after a suicide.
What have you observed about fears of keeping others close to you?

Often survivors struggle with redefining family and relationship roles. How have you been helped to redefine these roles? Is this new role a burden or a welcomed addition in your life? Please explain.

After a significant loss it is also common that survivors either become extremely independent or extremely dependent, what has helped you to learned to balance these?

What impact has the loss had on the relationship with your spouse or significant other? (If they are single, I will ask how the transition has impacted their dating experience, if at all.)

How have those significant to you assisted in the healing process? Have they inflicted more pain?

Many survivors find comfort in a religious or spiritual belief. How does or does not this fit you?

In your opinion, would family therapy be helpful to suicide survivors?
If yes, in what way? If no, what prevents it from being helpful?

APPENDIX C: RESEARCH PARTICIPANT RECRUITMENT LETTER

To Whom It May Concern:

Thank you for your consideration as a participant in this study. One of the most difficult situations that a person may face is the loss of a loved one by suicide. It is reported as one of the most difficult situations for therapists to address in treatment. In an effort to understand the process of healing from suicide bereavement, we are interviewing individuals who have experienced the suicide of someone dear to them. The focus of the interview is your experience of the bereavement process.

If you volunteer to participate in this study, you may choose the location of the interview. In the past, participants in similar studies have elected to be interviewed in their home or in the office of their therapist, with the therapist being present. You also have the option of being interviewed on UNLV campus or by telephone. The interview will take 45-60 minutes, and our conversation will be recorded with a digital recording device for later transcription.

Once the interview is complete, the interviews will be transcribed using aliases rather than your name to protect your identity, and all identifying information will be removed from the data. From there we'll analyze and compare your comments with those of other participants in order to identify themes and processes common for individuals who experience healing and positive progress.

Your experience with successful treatment is a valuable resource to new as well as experienced therapists who seek to better treatment models suicide bereavement.

TO PARTICIPATE:
Please contact **Quintin Hunt** via phone or email
(702) 751-6384
huntq@unlv.nevada.edu

We greatly appreciate your consideration. If you have any questions or concerns about the study, you may contact Dr. Katherine Hertlein at (702) 895-3210.

Sincerely,

Quintin Hunt
Student of Marriage and Family Therapy
University of Nevada, Las Vegas

Katherine Hertlein, Ph.D.
Program Director
Marriage and Family Therapy Program
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APPENDIX D: RECRUITMENT FLYER

What Works in Suicide Bereavement

What Helps and What Hurts?

- Have you experienced the suicide of a loved one?
- Are you 18 years or older?

If you meet the above criteria, your participation in a study about the grieving process of suicide survivors is requested. Our hope is to gain understanding of the grieving experience of those who have had a loved one die by suicide and to further understand how mental health professionals can better help.

Participation in this study is expected to take between 30-60 minutes. Interviews may be held on UNLV campus or at a location of your choosing.

If you are interested in participating in this study, please contact student researcher Quintin Hunt:

Phone: **(702) 751-6384**
Email: **huntq@unlv.nevada.edu**

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World Health Organization. (2012b). *Suicide prevention: SUPRE.* Retrieved November 20, 2012, from http://www.who.int/mental_health/media/unitstates.pdf

World Health Organization. (2012c). *Suicide prevention: SUPRE.* Retrieved November 20, 2012, from http://www.who.int/mental_health/media/repkor.pdf

World Health Organization. (2012d). *Suicide prevention: SUPRE.* Retrieved November 20, 2012, from http://www.who.int/mental_health/media/russ.pdf

CURRICULUM VITAE

Quintin A. Hunt

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Las Vegas, NV 89123
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EDUCATION

M.S.

University of Nevada, Las Vegas 2011 - 2013
Major: Marriage and Family Therapy
Thesis: *What works in suicide bereavement: What helps and what hurts?*

B.S.

Brigham Young University 2004 - 2011
Major: Marriage, Family, and Human Development

RESEACH EXPERIENCE

Thesis Research: Marriage and Family Therapy Program, University of Nevada, Las Vegas, July 2012-December 2013. Title: *What Works in Suicide Bereavement: What Helps and What Hurts?*

-Phenomenological study using a Grounded Theory protocol with six survivors of suicide.

Hertlein, K. M., Weeks, G. R., & Gambescia, N. (in preparation). *Systemic sex therapy* (2nd ed.). New York: Routledge.

-Reviewed and rewrote a current chapter, checked references for errors and new literature, created tables for inclusion in next edition. Updated chapters to reflect change from DSM-IV-TR to DSM 5.

Hertlein, K. M. & Blumer, M. L. (2014). *The couple and family technology framework: Intimate relationships in a digital age.* New York: Routledge.

-Reviewed chapters, checked references for errors.

Fife, S., Nemecek, R., Staples, J., Young, T., **Hunt, Q**., Ellis, A. & Peterson, C. (in preparation). Sexual Addiction in Family Systems Literature: A Content Analysis

-Analyzed journal articles pertaining to sex addiction and wrote results section.

Flourishing Families Observational Coding Lab at Brigham Young University

-Reviewed and coded video according to the Iowa Family Interaction Rating Scales

ACADEMIC AND PROFESSIONAL POSITIIONS

May 2013 – Present Student Intern at UNLV Center for Individual, Couple, and Family Counseling.

March 2013 – Present Sexual Addiction Facilitator at LifeSTAR of Las Vegas

-Curriculum research, development, and presentation

August 2012 – Present	Graduate Assistant, University of Nevada—Las Vegas
May 2012 – May 2013	Practicum student at UNLV Center for Individual, Couple and Family Counseling
August 2011 – August 2012	Psychosocial Rehabilitation Provider, Sage Health Services
August 2010 – July 2011	Mentor and Direct Care Staff, Maple Lake Academy

PUBLICATIONS

Hunt, Q. A. (2013, October). Perspective of marriage & family therapist in training. *Various Perspectives: October 2013 Hoarding Project Newsletter.* Retrieved from http://myemail.constantcontact.com/October-2013-Newsletter.html?soid=1109510086425&aid=xBwabVwcM8k#LETTER.BLOCK7

Hunt, Q. A. (2013). Student research summary. *American Association of Suicidology Student E-newsletter, 4*(3), 5.

Hunt, Q. A. (in press). Eating disorders: Decode the controlled chaos (Book Review). *The Therapist.*

Hunt, Q. A., Walker, L. T., & Marsar, T. N. (in press). Argo (Movie Review). *Journal of Feminist Family Therapy.*

SCHOLARSHIP IN PROGRESS

Publications in Review

Hunt, Q., Russo-Mitma, G., Olsen, C., & Nelson, M. (in review). Restorying interventions: Commemorating the past and embracing the future. *Journal of Family Psychotherapy.*

Peer Reviewed Publications in Preparation

Hunt, Q. A., & Hertlein, K. M. (in preparation). Conceptualizing suicide bereavement from an attachment lens.

Hunt, Q. A. & Weeks, G. R. (in preparation). Empirically-supported treatment after suicide.

Schonian, S., & **Hunt, Q. A.** (in preparation). Alcoholics anonymous and couple's therapy.

PROFESSIONAL PRESENTATIONS (REFERREED)

Fife, S., Nemecek, R., Staples, J., Ellis, A., **Hunt, Q.**, Young, T., & Peterson, C. *Still in the shadows: A content analysis of articles on sexual addiction and couple therapy.* (2013, November). Paper presented at the National Council of Family Relations Annual Conference, San Antonio.

Hunt, Q. A. *What works in suicide bereavement: What helps and what hurts?* (2013, September). Poster presented at the Nevada Marriage and Family Therapy Conference.

Ellis, A., **Hunt, Q.**, Young, T., Nemecek, R., Staples, J., Fife, S. T., & Peterson, C. *Still in the*

shadows: A content analysis of sexual addiction in couple therapy. (2013, April). Poster presented at the University of Nevada, Las Vegas Greenspun College of Urban Affairs Graduate Research Symposium.

Hunt, Q. A., & Russo-Mitma, G. *Closing one chapter, opening another: Obituary and birth announcement.* (2012, November). Poster presented at the Nevada Marriage and Family Therapy Conference.

PROFESSIONAL PRESENTATIONS (NON-REFERREED)

Ellis, A., **Hunt, Q.**, & Tielemans, S. (2013, July). *Pornography addiction.* Research presentation given to the Marriage and Family Therapy students at the University of Nevada, Las Vegas. July 9th, 2013.

Hunt, Q. A. (2012, December). *Suicide as an attachment injury.* Research presentation given to the Marriage and Family Therapy students at the University of Nevada, Las Vegas. December 10th, 2012.

GRANT FUNDING AND AWARDS

Hunt, Q. A.. *Suicide Bereavement: What Helps and What Hurts?* (2013). A grant proposal to fund a pilot study or dissertation on suicide bereavement. (*funding pending*)

PROFESSIONAL TRAININGS

ASIST Training	September 2013
EMDR Part I training by EMDR H.A.P.	February 2013
Discernment Counseling, Facilitators: William Doherty & Steven Harris	June 2012
Parts Psychology Workshop, Facilitator: Jay Noricks, Las Vegas, NV	July 2012
Emotionally-Focused Therapy Externship	September 2012
LifeSTAR Sexual Addiction Program	November 2011

PROFESSIONAL MEMBERSHIP/AFFILIATIONS

Professional Organizations

American Association of Suicidology	Fall 2013 – Present
National Council on Family Relations	Fall 2012 – Present
Delta Kappa Zeta, Marriage and Family Therapy Honor Society	Fall 2012 – Present
American Association of Marriage and Family Therapy	Fall 2011 – Present
Nevada Association of Marriage and Family Therapy	Fall 2011 – Present

COMMUNITY OUTREACH/MEDIA RELATIONS

Invited Public and Outreach Presentations/Lectures

Hunt, Q. A. (2013). *Stress management.* Conference presentation for the Warm Springs Stake of the Church of Jesus Christ of Latter-day Saints. September 14th, 2013.

Hunt, Q. A., & Clark, M. (2013). *Lifestar sexual addiction program.* Informative presentation about the LifeSTAR program for clinicians in the Las Vegas area. July 26th, 2013.

Hunt, Q. A. (2013). *Grief and loss*. Public presentation given to the women of the Gateway Ward of the Church of Jesus Christ of Latter-day Saints. March 19th, 2013.

Peterson, C., Fife, S., & **Hunt, Q. A.** (2012). *Pornography: The plague and the promises.* Presentation given to the ward of the Seven Hills Ward of the Church of Jesus Christ of Latter-day Saints. December 2nd, 2012.

Robinson, M., **Hunt, Q.**, Hoffman, C., & Holden, N. (2011). *Suicide awareness and prevention: Learn how to help your loved ones.* Public presentation given to members of the Provo, Utah community. March 9th, 2011.

Blog Posts

Hunt, Q. A. (2013, October 11). Suicide bereavement: I'm feeling a little angry/mad today. [Web log post]. Retrieved from anmftblog.blogspot.com.